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ABSTRACT

The prevention of handicapping conditions and the reduction of failure and disaffection in schools is the topic of this booklet, one of 16 texts designed for use in an Open University course on the education of handicapped students in the United Kingdom. Medical approaches to prevention, including those involving ethical issues, are explored. Examples of primary, secondary, and tertiary prevention are given, and court cases are introduced to illustrate the range of ethical and moral considerations involved. In a section on at-risk children, development of screening procedures in schools is considered, as are preschool home intervention approaches and the underlying theories of compensatory education. Scottish attempts to reform the curriculum and school organization are cited as one example of efforts to change the educational system, thereby reducing the ill effects of school on children. A final section considers factors that limit change but also notes the possibility of positive change. The appendixes summarize reactions of Scottish teachers to their new roles and present a brief case study of a preschool community project in Scotland. (CL)

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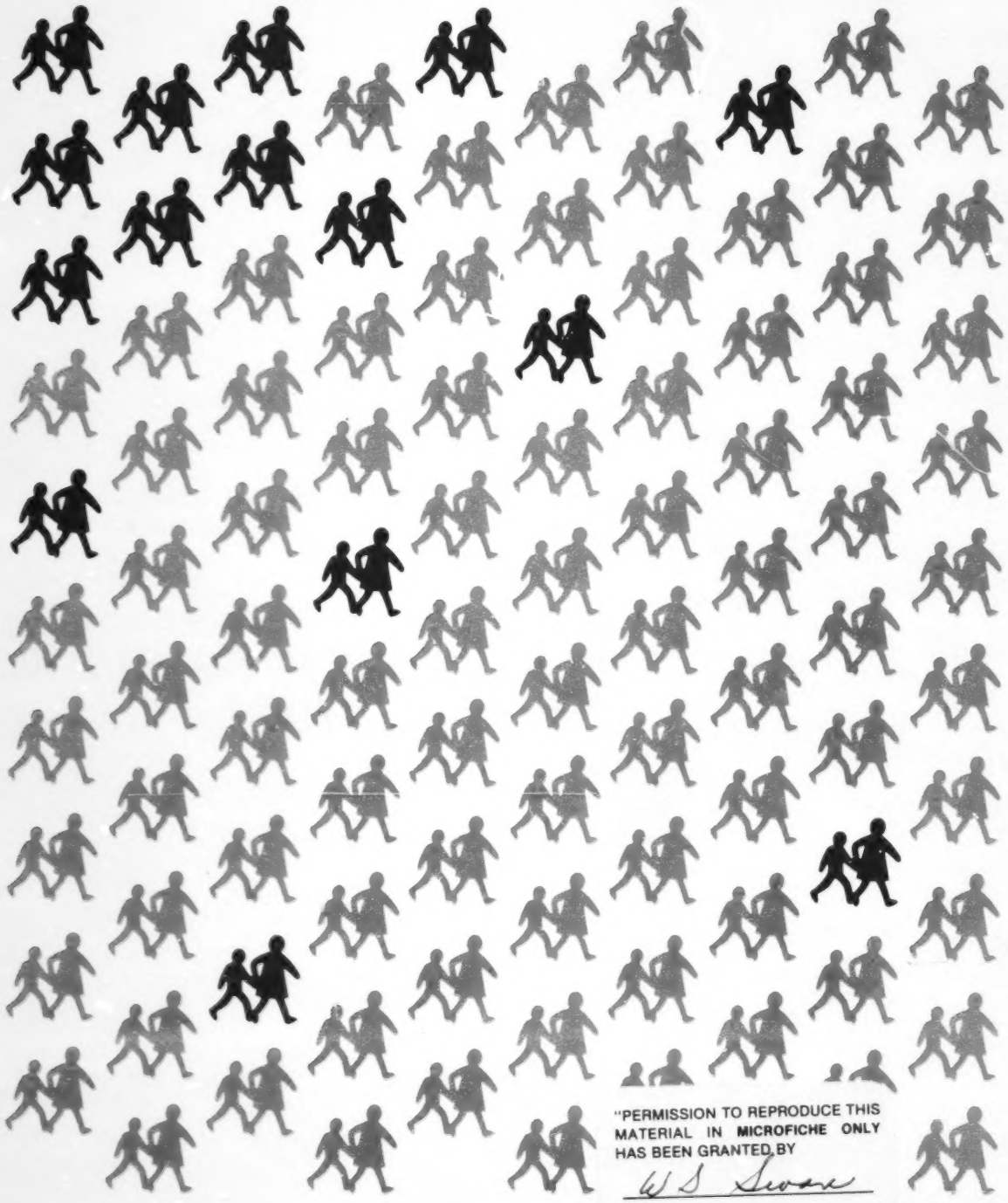

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The Open University
Educational Studies: A Second Level Course
E241 Special Needs in Education

Unit 14
Eradicating handicap

Prepared by Tony Booth for the Course Team

The Open University Press

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Note on reading

Set reading

The reading for this unit is to be found in:

SWANN, W. (ed.) (1981) *The Practice of Special Education*, Oxford, Basil Blackwell/ The Open University (the Reader). It is:

HALSEY, A. H. (1980) 'Education can compensate' (Reading 5.4).

The case studies for this unit are to be found in:

BOOTH, T. and STATHAM, J. (1982) *The Nature of Special Education*, London, Croom Helm/The Open University. They are:

'The prevention business' (Case study 30).

'Westhall School for children with learning difficulties' (Case study 45).

You will also be required to read the three appendices.

Broadcasts

Television programme 7 and Radio programme 7 are part of this unit. Further details can be found in the *Broadcast Notes*.

Medical prevention—political priorities?

Costs 'killing' kidney children

Lack of money and donors deny the young vital treatment. Andrew Veitch reports

MARK JARVIS is lucky. A kidney transplant on Christmas Eve saved his life. But lack of money, and a shortage of donors, mean that every year in Britain between 30 and 50 children die of kidney failure.

Mark is nearly three. If he had been born two years earlier, his chances of survival would have been halved. Ten years ago he would have died. He is alive because doctors have made rapid progress in identifying, preventing, and treating kidney disorders.

His mother, Rose, hopes that within a month she will be able to take him home to his twin Edward, and six-year-old brother in Durrington, Wiltshire. The transplant, one of five so far performed on babies at Guy's Hospital, London, appears to have worked, and a congenital obstruction in his urethral valve has been cleared.

Funds for kidney units are running seriously short. About half the 2,200 people whose kidneys fail, die because there are no facilities to save them, Professor Cyril Chantler of Guy's Hospital said yesterday. Most are over 45, but only 61 children under 15 were treated in 1980, while an estimated 90 suffered fatal kidney failure.

"If there was enough money to treat every kidney failure, we would be treating 1,000 more patients a year and would save hundreds of lives," he said. Britain is 16th in the European league for kidney treatment. The Swiss do more, and both Spain and Cyprus treat more patients per head of population.

It costs £10,000 a year to keep someone on a kidney machine. A transplant costs £5,000 a year for five years. So prevention not only saves lives, it makes economic sense, said Professor Chantler.

Professor Cyril Chantler of Guy's Hospital with young kidney patients Mark Jarvis, aged three, and Nicholas Corne, one. **Picture by E. Hamilton West**

The Guardian, *15 January 1982.*

1 *Introduction*

1.1 In this unit I will examine a variety of approaches to the prevention of handicap and the reduction of failure and disaffection in schools. In order to understand what can be prevented we have to know who the handicapped are and how their handicaps are produced. I will expect you to draw on the information and conclusions of earlier units of the course, particularly Units 11, 12 and 13, in order to answer those questions.

1.2 The title of this unit, *Eradicating handicap*, is intended as a provocation rather than a promise. Handicaps arise as a result of a complex set of interactions; unlike malaria or diphtheria, they cannot be removed totally by attacking a small set of root causes. We could never prevent the occurrence of physical disabilities for becoming disabled is a normal part of growing old. But while we can do little to alter physical decline in old age, there is much we could do, in theory, to improve the lives of old people—to reduce the handicapping effects of their physical impairments. Understanding the nature of their handicaps and the ways in which such handicaps are produced is the first step in reducing their burdens. But gaining such understanding is no guarantee that any effort to improve their situation will be made. As you and I know, there are formidable obstacles to changing people's lives.

1.3 In the next section I will look at medical approaches to prevention. As you may be aware, these involve far more than a dispassionate application of medical science to the eradication of disorders of health. They do include the relatively uncontroversial treatment of phenylketonuria at birth and the innoculation of girls against rubella. But they also involve ethical judgements, as when amniocentesis is used to detect abnormality in a foetus, and over the choice of whether babies born with Down's Syndrome or spina bifida should be allowed to survive. While these issues have raised the most obvious moral concerns about abortion, euthanasia and the value of life, all forms of medical intervention involve moral decisions about priorities in the allocation of scarce resources.

1.4 In section 3, I will look at early intervention schemes which have focused on the child with a problem either in school or at home. Many of these schemes have conformed closely to a medical model and were quite consciously related to forms of medical intervention. In one way or another, they all involved the selection of a group 'at risk' of a future difficulty and the implementation of a subsequent plan of action. I will look first at the development of screening procedures in schools, next at pre-school home intervention schemes such as 'Portage', then briefly at the ideas behind early compensatory education plans. These various approaches are all thought of as preventive by their practitioners, though as you will see they involve children of a wide range of ages.

1.5 In section 4, I look at the development of policies towards children with learning difficulties in Scotland. Scottish educationalists have been trying to tackle the problems of failure in school, particularly at secondary level, by attempting to reform the curriculum and organization of the school, and by using remedial teachers in a new role involving team teaching and curriculum development. This focus on what goes on in schools themselves, and on LEA and national policies for changing it, echoes the messages from Unit 13 and Television programme 7.

1.6 In the final section, 'What has to change?', I re-examine some of the forces which limit the possibility of avoiding failure, disaffection and handicap. In this unit, as in Unit 13, I attempt to steer a course between what I see as the considerable barriers to change and progress, and an emphasis on the necessity for concerted action if such barriers are to be overcome. The result reflects my own balance between optimism and pessimism. It is up to you to work out from your knowledge and experience, and from the material that is presented to you, your own view of the extent to which educational difficulties and handicaps of all kinds can be alleviated.

Reading Now read Case study 30, 'The prevention business'. It is an edited transcript of a discussion between six people all with a background in psychology, most of whom had a professional interest in reducing handicap. It serves as an introduction to the main issues of the unit.

Comment (a) It is unlikely that 50 per cent of mental handicap could be 'removed' by prenatal action. Abortion and even euthanasia at birth are often regarded as preventive, though some people would disagree that any such measures could be called prevention.

(b) Sonia (p. 193) argues that it is the business of professionals to prevent the birth of children with genetic defects and that this consideration might override the need to give parents realistic information. The handicaps she lists as arising from Down's Syndrome are clearly socially produced, yet she argues that these should be used as reasons for abortion: 'they are certainties'.

(c) Chris (p. 194) sees restraint on reproduction amongst some handicapped people as a desirable form of prevention. Does he mean sterilization? A number of young mentally and multiply handicapped girls are sterilized at the moment and, as a court case a few years ago illustrated, the practice is sometimes extended to the mildly handicapped (Loxley, 1975/6). How do you decide who should be sterilized?

(d) Both Chris and Richard draw attention to the interest of some people in special education in keeping up the numbers of children identified as handicapped (p. 19[illegible]).

(e) The idea of prevention as the avoidance of the birth of a handicapped child is broadened in the discussion to include actions taken to support families with handicapped children, working with families to overcome problems, the setting up of support groups and community centres, and the identification and treatment of children with learning difficulties in schools. The appropriate form that intervention in schools might take is a major theme of this unit. Should intervention be aimed at the child, the teacher, the school, the LEA or at the creation of national policy?

(f) Richard, on p. 197 and again on p. 199, challenges the effectiveness of early intervention programmes and 'sophisticated' screening methods.

(g) Simon draws attention (p. 200) to the association between screening devices for children with learning difficulties and particular behaviourist teaching methods. This 'package' deal will be discussed in section 3 of this unit.

(h) Both Simon and Richard (pp. 199–200) challenge the idea that early intervention when employed as the only strategy of intervention could prevent problems arising later for children: 'It must be a myth that if you got all the kids early enough and did all the right things, there would be no more problems.' As we shall see, strategies for early intervention are sometimes based on a medical/clinical view of handicap in which early treatment of children 'at risk' prevents the development of difficulties. How appropriate is this strategy?

(i) Richard (pp. 200–201) argues that many school problems, particularly the most intransigent, are related to persistent social difficulties. The families to which he refers become thought of as 'problem families' for whom an interminable amount of support often yields little change. The Taylor family of Case study 12 might be labelled in that way. As you see, some members of the *caring* professions (Chris, p. 202) believe there are undeserving poor who don't put enough into society to expect any support. How did you feel about the Nelson family of Case study 18? Such a view has many deficiencies, not least of which is the implication that 'being undeserving' can be inherited by children from their parents.

(j) Richard (pp. 202–203) displays both a streak of pessimism and a recognition that as an educational psychologist he has to do something 'tomorrow'. Remember, of course, that professionals are not paid to admit that they can do nothing. I would argue that at the very least individuals within welfare services have to co-ordinate their activities within the policy of their local authority. If they don't, they may well find themselves working against each other, attempting to establish conflicting forms of provision or presenting families and children with conflicting advice. The image of professionals moving around their patch alternately digging their own holes and filling in those dug by other professionals is in my experience an accurate depiction of much welfare work.

2 *Promoting health, preventing handicap*

2.1 In this section, I will examine medical efforts to reduce the numbers of children growing up with impairments. These efforts are sometimes divided into primary, secondary and tertiary prevention, although only primary prevention actually involves avoiding the occurrence of impairment.

Three sorts of prevention

Primary prevention

2.2 Unit 11 described one example of primary prevention, genetic counselling for people with an increased chance of producing a child with an impairment because they carry a recessive 'handicapping' gene. Vaccination against rubella is another example. After an epidemic of German measles in 1978–9, there was a national campaign to immunize all girls between the ages of 11 and 14 against it. Pregnant women who have German measles in the early months of pregnancy have a considerable risk of producing a baby who is retarded, or who has defects of the heart, hearing and sight. It is estimated that each year 50 babies are born with some effect of rubella. All women contemplating pregnancy were also encouraged to be vaccinated, which had the unintended consequence that 30 per cent of the women who had abortions because of rubella in the early months of pregnancy actually caught the rubella from the vaccination (Banatvala, 1982). As yet there has been no decline in the incidence of rubella-infected babies, for it is early in the campaign and girls aged 11–14 in 1979 are now aged only 14–17 and few have had babies. There are, however, some indications that the campaign may not be as successful as was hoped. It was aimed at producing immunity only in women rather than in the population as a whole, so that the resulting pool of immunity could stop any outbreak from spreading. It is therefore heavily dependent on the extent to which it is taken up by girls, and on the length of time immunity lasts. There is some evidence that immunity decreases after a few years and that only about 75 per cent of girls lacking immunity have been vaccinated. One group of doctors found a greater interest in and agreement to the procedure when it was based on their general practice (Hutchinson and Thompson, 1982).

2.3 As yet there is no immunization against cytomegalovirus (CMV), though this has been said to affect far more babies than rubella; Dudgeon (1976) estimates that between 400 and 800 babies are affected a year, and its most extreme effects are said to be the production of mental handicap, cerebral palsy, hydrocephalus, deafness and visual defects. Mencap is pressing for the development of a vaccine against it. The numbers said to be affected by medical conditions such as CMV have to be treated with extreme caution, however. They may be based on the presence of slight symptoms which could have resulted from numerous causes. As Patricia Potts described in Unit 11, restlessness and involuntary activity can result from damage to the brain, but in the vast majority of cases there is no evidence that it occurs for this reason rather than another.

2.4 As you are aware from earlier units, medical interventions aimed at preventing handicap may actually be responsible for it. Innoculation against whooping cough in young children is sometimes avoided by parents because of the publicity surrounding cases where the vaccine itself has produced extensive brain damage.

2.5 A third example of primary prevention concerns recent evidence that the incidence of women who have already had one spina bifida child producing a second may be reduced by their taking vitamin supplements for a month before and two months after the conception of their next child. Such women would normally have a considerably increased risk of producing a second child with spina bifida (approximately 1 in 20) but only one in nearly 200 of the women treated had such a child (Smithels *et al.*, 1980). There is an attempt at the moment to reproduce these findings through a more rigorous investigation but there are formidable ethical problems involved in withholding vitamin supplementation from a controlled group of women at risk of producing deformed babies.

2.6 Despite what Professor John Lorber (in an interview for this course) has described as the 'disastrously exciting' nature of this work, there are some doubts about whether the early findings will prove to be robust. Are the vitamins intended to remedy a deficiency or is it the increased dosage which is meant to have an effect? If it is a deficiency that is meant to be the cause, have the women for whom an effect is claimed been shown to have an abnormally deficient level of vitamins in their blood? In the same interview Professor Lorber argued, 'one thing, perhaps more than any other, which makes any such theory almost impossible to hold in spite of the apparent evidence is that spina bifida rarely occurs in both twins, even in identical twins. I find it very difficult to understand how more vitamin gets into one twin than into the other.'

Secondary prevention

2.7 The treatment of phenylketonuria (PKU) is an example of secondary prevention in which a condition present at birth can be almost completely alleviated by prompt medical intervention. Screening babies at birth for the presence of PKU is now routine. Hypothyroidism is another condition which can be 'prevented' in this way, though, as you saw from the case study of the Barker family, it is not always detected early enough.

Tertiary prevention

2.8 At present in the UK, the number of impairments avoided by primary or secondary medical intervention is relatively small. Most attention has been focused on what has been euphemistically called 'tertiary prevention', in which an 'impaired' foetus is detected by amniocentesis or ultrasound and then aborted, or a new-born baby is 'allowed to die' or is killed because it has a severe physical disability or has Down's Syndrome. I will take a closer look at the considerations governing medical practice in such cases later in this section. But first I want to examine a recent controversy in which it has been argued that as many as 5000 babies a year could be born without physical handicap by improvements in obstetric practice and perinatal care.

Can 5000 babies a year be saved?

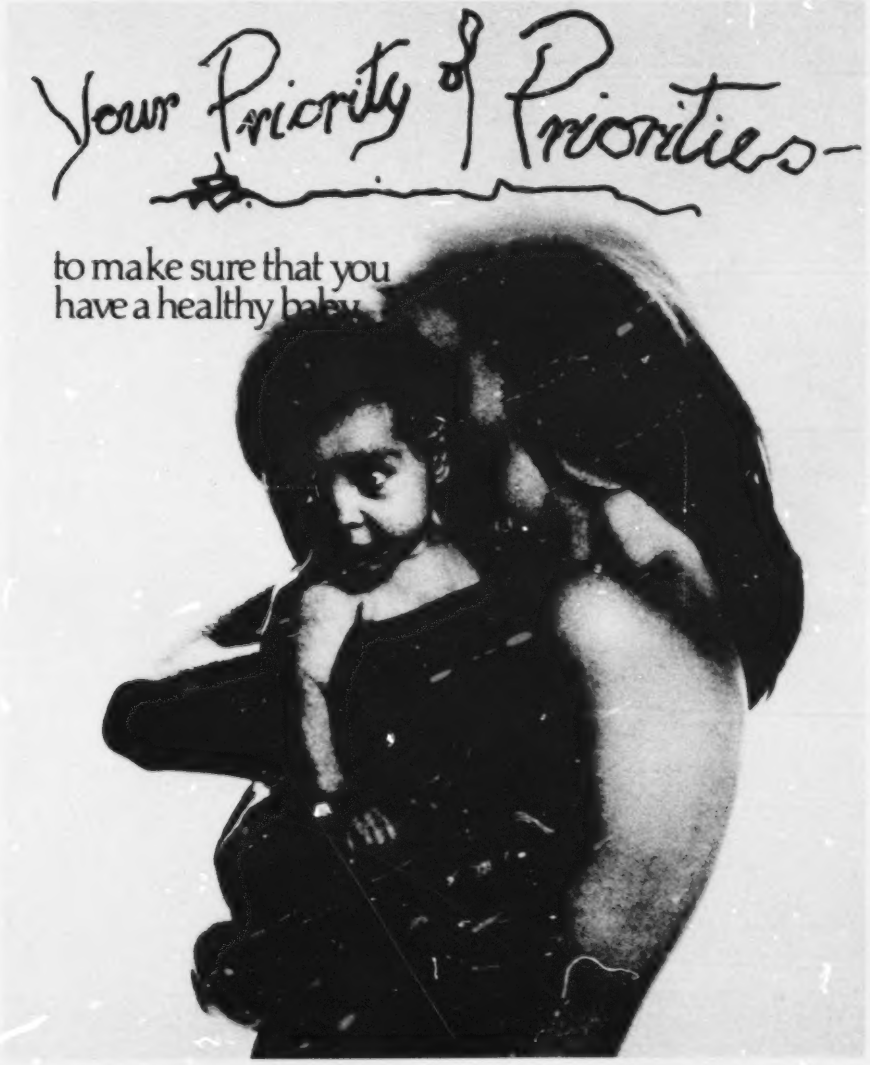
2.9 In 1978 the Spastics Society launched the first stage of their 'save-a-baby' campaign in which they claimed that out of the six babies born with cerebral palsy each day, 'at least two—and possibly three—could have been healthy and normal with proper care of mother and child'. This suggests that between 700–1000 cases of cerebral palsy could be prevented each year. They based their figures on a comparison of the statistics of perinatal mortality rates in the developed countries (the perinatal mortality rate is the proportion of the total number of babies born who are dead at birth or who die in the first week after birth). The perinatal mortality rate *has* fallen steadily in England and Wales: by a factor of four since 1930 (Office of Health Economics, 1979). But the rates in France and Sweden were said to be much lower. The assertions about handicapped babies rest on the belief that the improvements in medical care which would lead to an reduction in perinatal death would also lessen the production of handicap by an ill-managed birth. This belief in turn is based on evidence that babies of low birthweight are disproportionately likely to be born dead or damaged and this applies particularly to babies who are small for their foetal age—'small-for-dates babies'. According to a number of people, many such deaths and handicaps could be prevented by a wider introduction of special-care baby units. One doctor claimed: 'If they had the same type of services as the Swedes do, we would save almost 5000 babies from dying' (Dr Appleyard, quoted in *The Guardian*, 1 October 1979).

2.10 As a result of pressure, largely from the Spastics Society, the Social Services and Employment Subcommittee of the House of Commons set up an enquiry into perinatal and neonatal mortality (i.e. deaths occurring up to the end of the first month after birth). In its findings, published in July 1980, it made the claim that with the universal application of modern knowledge and care '3000–5000' deaths could be avoided, and that 'the number of children surviving each year with important handicaps which could have been prevented is probably at least 5000' (House of Commons Social Services Committee, 1980). Claims about the number of preventable handicaps had risen, then, to 5000 per year or, taking the 16 years up to the end of compulsory schooling, 80,000 children could

be without handicaps given proper medical care before and shortly after birth. One estimate of the total numbers of physically handicapped children under the age of 16 is 100,000 (Office of Health Economics, 1979).

2.11 The Spastics Society campaign was primarily inspired by French efforts to deliberately reduce the numbers of children born with handicaps, linked to an estimated saving in public expenditure through the avoidance of educational, medical, and institutional care associated with severe handicap. But the performance of the French as well as other countries has been challenged: '[although] it has been claimed that France, Finland and Japan have fewer handicapped babies than Britain . . . the lack of routine handicap statistics in any of these countries make it impossible to assess the validity of the assertions' (McFarlane, 1981). And even the reduction in perinatal mortality rate on which the assumptions about handicap were premised are said to be 'exaggerated': 'France has frequently been favourably compared to Britain. But, in fact, its reported 1975 perinatal mortality rate was . . . slightly above that for England and Wales in 1976' (Office of Health Economics, 1979).

2.12 As yet there is no clear proof 'that measures taken to prevent death, in particular intensive care of very ill or small newborn babies, will necessarily also reduce the risk of handicap [for since] intensive care may prevent the death of the very babies who are already handicapped or who are at the greatest risk of becoming handicapped, there is a real danger that the overall number of handicapped children surviving could actually



A photograph used by the Spastics Society in their campaign to reduce the number of children born with handicaps—but are people with cerebral palsy unhealthy?

increase (McFarlane, 1981, p. 10). Despite the fact that perinatal mortality rates have fallen steadily, there are no definite statistics which show that the overall rate of handicap after birth has fallen or risen.

2.13 The reasons for a country having a high or low perinatal mortality rate have resisted explanation. As Figures 1a and 1b show, there is little relationship between perinatal mortality and either *per capita* health expenditure or number of doctors. It is true that Sweden has a lower perinatal mortality rate than England and Wales, that the Swedes do spend more money on medical care during pregnancy and during birth, and that much of this investment takes the form of high technology medicine: foetal monitoring and special care units. However, although many more small babies are born in the UK than in Sweden, and small babies have a high risk of dying or being handicapped, the chances of survival of small babies is actually as good in England and Wales as it is in Sweden. The regional variations in perinatal mortality rates in England and Wales coincide with variations in the number of small babies born. If we wish to account for the difference in perinatal mortality rates between Sweden and the UK, we may need to find out why there are more small babies born in the UK. An attempt to reduce the numbers of small babies would lead us away from a concentration on events surrounding birth and to factors affecting the development of the child during pregnancy. We do, however, have to remember that though there is an association between birth weight and perinatal mortality rate, many of the babies that die at birth or are born handicapped are *not* of low birth weight.

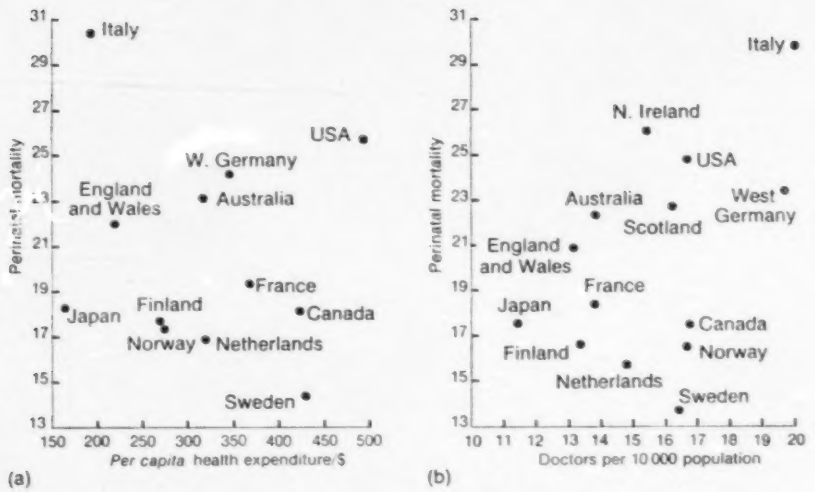


Figure 1 Relationship between perinatal mortality, health expenditure, and number of doctors: (*a*) per capita *health expenditure* (*b*) *doctors per 10 000 population*
Source: Office of Health Economics (1979).

2.14 Why then are some babies born small and why are there more small babies in the UK than in Sweden? According to McFarlane, the statistician with the National Perinatal Epidemiology unit:

> The proportion of small babies born is . . . strongly associated with the parents' socio-economic background—working class women have a higher chance of having a small baby than do middle class women. They also have a higher chance of having a baby with a malformation which is incompatible with life. (McFarlane, 1981, p. 11)

If it is true that birth impairments and perinatal mortality rates are 'a question of class', as the Office of Health Economics (1979) report suggests, does this mean that appropriate intervention lies outside the National Health Service? This is what the Baird Committee, who produced the report *You and Your Baby* in Northern Ireland, argued:

> Many of the factors which affect the outcome of pregnancy lie outside the traditional scope of the health services . . . we believe that prevention of death and handicap begins in the socio-economic sphere . . . greater prosperity, full

employment and adequate housing would in themselves make a larger impact on the problem than would changes in the nature and organization of services.

(DHSS, Northern Ireland, 1980)

2.15 How does being born to low-income parents lead to greater vulnerability to death, handicap and accident? In the case of childhood accidents the association may be totally straightforward. The incidence of child burn and scald accidents in Bradford was found to be greatest in overcrowded houses which lacked hot water (Learmonth, 1979). There may be an equally direct connection between extreme hardship and the development of the baby if this means that mother and child get insufficient or inadequate food or rest or peace. The payment of maternity benefits which are unrelated to National Insurance contributions is the least change that should be made. But there is also a clear relationship between social class and the take-up of services that are offered.

2.16 Maternal and baby care offered by doctors is not uniformly welcoming. Some people persist in attending antenatal clinics in spite of the apparent efforts to make them feel ill at ease while they are there, as Patricia Potts found and reported in *The Guardian*:

Ante-natal, anti-natal?

Be seen and not heard. Do not speak unless spoken to. These familiar constraints may no longer be *de rigeur* for children but they certainly are for their expectant mothers.

In the fug of the waiting-room we compare paunches, watch nurses dart in and out, and trek off to produce a sample in a huge glass vase. The starting-gun is eventually fired by the receptionist and we line up to get our queue-ticket. This short period of fairly meaningful activity is the last for some time.

A smiling nurse will invite you to step into a cubicle, of which there are several down one side of the waiting-room. Here, the torpor, stuffy quiet, and bewilderment only increase. There is a lofty ceiling and a bright light; two doors and no window. Despite the isolation one is still vulnerable, however, stripped for the examination and wearing a uniform robe with no fastenings, like desperadoes deprived of boot-laces, nail-files, and every bit of string.

All the pleasurable anticipation, the excited impatience, even, to discover more about the baby drains away and by the time the second door is opened we have turned into sweaty, angry, anxious but enervated hunks of flesh.

Now the pace changes dramatically; we are swept up into the tidal stream, placed on trolleys in loading-bays magically in touch with the vital current, the nerve-centre of operations, a fast lane in which a white coat flashes by overtaking and leaves a spray of nurses, medical students and junior doctors, strictly in that order.

The action is now prestissimo, the mystique maintained by sleight of hand rather than elaborate ritual, but we are still in an almost silent movie. Fragments of speech decline sharply as status rises. Patients who are shy, depressed by the rows of anonymous women or fearful of experts, will not learn a thing from the examination. Unless an expectant mother repeatedly takes the initiative from her prone and exposed position she will remain ignorant, treated like a complete dependant. But when the baby is born, she will be expected to be responsible, well-informed, confident.

Suddenly, the escalator stops and we are deposited back in the outer waiting-room. What now? It is hard to believe that lack of attention bodes well. We should be feeling buoyant, reassured, not exhausted and fed up. No one wants to have complications to spellbind a lecture audience or add spice to a consultant's case-book, and few would want to become matey or confessive with the doctors. But there's something devastating about the social, sexist imbalance and it has nothing to do with the numbers of women who have to be seen at each clinic. No wonder we take our mums or best friends. It's like 'zoo-time' without any cakes. And it's not surprising that attendance at ante-natal clinics is not always good.

The professional distance is neither a comfort nor a support and if you were on the look out for a sharing of knowledge, think again. They say the care is excellent so we enlist with the captive clientele, but the education is nil. We rely on our GPs, National Childbirth Trust classes and reference books to keep us away from the hospitals as long as possible. As concrete shrines to medical power they are very likely to make us feel anti-natal.

(*The Guardian*, 10 March 1980, p. 8)

2.17 Many doctors argue that handicap and perinatal mortality are causally linked to non-attendance at ante-natal clinics. If the actions of some doctors make it unpleasant for women to use these services, what responsibility must such doctors bear for the effects of their actions?

2.18 In a poor area of Stockton-on-Tees, one GP/obstetrician has established a system of health care during pregnancy which has reduced the perinatal mortality rate to one half the national average in his area, by focusing his efforts on reaching women in 'high risk' categories (Marsh, 1977). A change in policy at Sighthill in Edinburgh also seems to have had dramatic results. They have moved from hospital- to community-based service and have devolved responsibility from consultants to community midwives. Ninety-five per cent of women are now seen before the 16th week of pregnancy as against 63 per cent before the scheme started. The perinatal mortality rate has dropped from 27 per 1000 to eight per 1000 and the incidence of low birthweight and prematurity have been halved (McKee, 1982). Why aren't such community-based services more generally available? The difference in background between doctors and many of their clients may prevent them from seeing their clients' point of view, and this may be exacerbated by professional distance and sexism. But are there other forces which make the development of community health care difficult?

2.19 I mentioned earlier in this section that some people have advocated more technologically based medicine as the means of reducing infant mortality and handicap. A group of obstetricians who met to discuss the prevention of disability, and whose recommendations were reported in an article headed 'Research could halve severe disability in early life', mentioned the detection of oxygen lack during birth:

> An insufficient supply of oxygen is probably the most important cause of brain damage just before, during and after delivery of the premature baby. The early detection of oxygen lack helps the obstetrician to speed up delivery. There are now promising methods of detecting oxygen lack, before the onset of labour, through monitoring the heart rate, the respiratory rate and the movements of the foetus. More work needs to be done before these techniques can be applied as a regular routine.
>
> During labour the detection of oxygen lack is already possible and depends on monitoring foetal heart rate and on chemical examination of the infant's blood. These methods require to be refined so that Caesarean sections to speed up delivery are not carried out unnecessarily.
>
> (Wolff, 1980)

2.20 There is pressure for high technology medicine from some hospital-based doctors, as well as the more obvious commercial pressures of the manufacturers of monitoring equipment. But, just as in special education, there is only a tenuous link between research evidence and the introduction of a new practice. McFarlane reported that, out of four trials to compare deliveries which did and did not use electronic foetal monitoring, only one found any advantage for babies from its use, and all the trials showed that foetal monitoring produced double the rate of Caesarean birth as that in the control groups. Another study had documented adverse effects which could arise from the constraint on movement caused by the attachment of monitoring wires to the baby's scalp during labour. The authors found that 'women who are free to take up whatever position they wish in early stages of labour have, on average, shorter labours and develop fewer complications than those required to stay lying down' (McFarlane, 1981).

2.21 McFarlane imputed 'a more subtle pressure predisposing towards technological intervention in childbirth' which is 'the long standing desire on the part of obstetricians to bring pregnancy and childbirth under medical control'. And on the basis of the available evidence she echoes the conclusion of Ian Chalmers: 'In the light of the difficulties in assessing which aspects of perinatal practice are most likely to have a beneficial effect on mortality and handicap, perhaps the primary objective should be to please the customers' (Chalmers, 1980).

2.22 As you can see, medical prevention involves political and moral questions as well as practical decisions. I want to turn now to a number of questions which raise the most fundamental moral dilemmas. Should some handicapped babies be killed at birth? Should the presence or suspected presence of a disability in a developing foetus be a reason for abortion? How do such considerations affect our attitude to disabled children and adults? Who should make decisions about the fate of handicapped babies? In 1981, the International Year of the Disabled, such questions received considerable attention from the media, partly provoked by two court cases. One involved a civil action brought by Hammersmith Social Services Department to force a hospital to operate on a baby girl with Down's Syndrome who had an intestinal blockage. The second started as a murder prosecution against a doctor who had prescribed a tranquillizing drug and minimum care to an apparently healthy baby with Down's Syndrome who was rejected by his parents. The discussions and court cases emphasized the tremendous disparities in practice between different doctors and different areas of the country.

Guidelines for spina bifida babies

2.23 Until recently, most of the discussion about survival of handicapped babies had been concerned with spina bifida. The doctor's dilemmas had been highlighted in these cases by the advent of new medical technology: the fitting of valves to drain away the excess cerebrospinal fluid to prevent the build-up of cranial pressure and consequent brain damage. Eckstein *et al.* (1973) produced a classification of 'congenital abnormalities' on which decisions about the survival of babies might be based which reflect the primary concern with this group of infants:

> *Group I* Infants with abnormalities which are incompatible with life if untreated . . . [such as a blocked intestine] . . . and total recovery in a normal child can be expected after surgical treatment. Such infants are treated energetically at all times and present no moral or ethical problems.
>
> *Group II* Infants with severe abnormalities which are incompatible with life even with present day treatment. These include anencephaly. Again, no moral or ethical complications are involved.
>
> *Group III* Infants with abnormalities from which they would die if untreated but where surgical treatment will preserve life but the child will never be normal. This group includes . . . duodenal atresia when associated with Down's Syndrome. Selection in this group presents enormous problems and in practice most infants are treated actively as the severity of their ultimate handicap cannot be assessed in the first few days of life.
>
> *Group IV* Infants with congenital abnormalities which are likely but by no means certain to be fatal, and who if untreated may survive with more severe handicap than if treated. This group fundamentally embraces the whole problem of spina bifida and presents enormous moral and ethical implications.
>
> (Eckstein *et al.*, 1973)

2.24 The late fifties, as has been mentioned at various points in the course, saw a considerable shift in efforts to keep spina bifida babies alive through the new valve operation, though many had a much more severe degree of physical disability after the operation than had been hoped. In 1971, Professor Lorber produced a report on what had happened to a large number of children who had either been operated on or not. His report was highly influential in establishing criteria for selecting which babies should be operated on. Operation was recommended only if the baby was not grossly paralysed and did not have severe enlargement of the head, severe spinal distortion or other congenital defects (Lorber, 1971). By the end of the seventies the vast majority of babies with spina bifida did not survive until their first birthday.

2.25 However, the fact that there had been a general shift in medical practice did not mean that all doctors or parents were in agreement. Dr Hugh Jolly, who ran the paediatric department at Charing Cross Hospital, explained on ATV's *Live or Let Die?* in March 1981 how spina bifida babies with little chance of 'normal' life were given drugs to sedate them and suppress their appetite, then fed only water until they died. Other doctors on the programme expressed vehement criticism of this approach and argued that all babies should be given the medical treatment necessary to preserve their lives.

The introduction of screening

2.26 In her comments on infantile euthanasia, Polly Toynbee remarked in *The Guardian:*

> The real tragedy, the real scandal is that so many handicapped babies are ever born in the first place . . .
>
> Across the grey area between abortion and infanticide, society has, for the time being, arbitrarily drawn the line at the twentieth week of gestation. No woman should have to suffer the torment of giving birth to an unwanted handicapped child, nor should doctors have to take unbearable decisions. There is only one socially acceptable alternative: to give all women the opportunity to be screened in early pregnancy.
>
> (*The Guardian*, 23 October 1981)

2.27 Certainly the possibility of screening introduced a number of new elements into the debate and may have affected attitudes towards both spina bifida babies and the spread of the practice of infantile euthanasia to Down's Syndrome babies.

2.28 In recent years alphafeto-protein testing, the use of ultrasound and amniocentesis have become commonplace, though there is little public knowledge and debate about their physical effects and the moral repercussions of adopting a screening mentality.

2.29 All women who attend an ante-natal clinic are given a routine blood test early in pregnancy which, among other things, screens for syphilis and may involve, depending on the area in which they live, measures of rubella immunity and alphafeto-protein levels. Alphafeto-protein is a normal foetal protein which passes into the amniotic fluid, rises to a peak in the first three months of pregnancy and then falls rapidly. Raised levels for the age of the foetus have been found to be associated with severe spina bifida in which an open wound is present. To establish whether the level for dates is raised, an accurate assessment of the age of the foetus is made by obtaining a picture by using high frequency sound waves in a technique known as ultrasound scanning. A high level of alphafeto-protein can occur in maternal blood for many reasons and its origin is checked by amniocentesis. This involves the withdrawal of a small amount of amniotic fluid from the uterus using a hollow needle and is generally used in association with ultrasound to check the foetal position (see *Glossary*). A high level of alphafeto-protein in the amniotic fluid is found in ten per cent of those cases where a high level had been detected by the blood test and this is a reliable indicator that the foetus has a defect (usually spina bifida). This may be further checked using a high resolution ultrasound scan. The series of procedures can detect only severe cases of spina bifida (Harris, 1980).

Ultrasound scanning.

2.30 Amniocentesis is most commonly used to screen for Down's Syndrome in older pregnant women who have an increased risk of conceiving such a child, although relatively few women over 35 give birth. Screening, therefore, can only detect a small proportion of foetuses with Down's Syndrome, for most are in fact born to younger mothers. During amniocentesis there is a small but significant risk that the needle will harm the foetus or even cause an abortion. It also produces a 15 per cent rate of false results: some babies are born with Down's Syndrome in spite of a 'negative' test, and others who are aborted after the test results are 'positive' are found not to have Down's Syndrome. A group of doctors in Oxfordshire estimated that with one screening policy, a similar number of babies with and without Down's Syndrome would be aborted (McFarlane, personal communication). In November 1981 the Leeds Area Health Authority was sued for negligence when, following a 'negative' amniocentesis result, a woman had a baby with Down's Syndrome who had a serious heart defect and died aged 13 months. The 'mistake' was attributed to human error rather than the limitations of the test and the scientific officer responsible for the test resigned (*The Guardian*, 18 November 1981). The expense of the test, in terms of equipment and staff, has led to studies of the break-even point where the projected costs of care for the possibly handicapped children are equal to the costs of amniocentesis (Hagard and Carter, 1976). They suggest that these costs balance when only women aged 35 and over are tested, though what should or shouldn't be included in the costs is open to dispute.

The moral implications of screening

2.31 The use of amniocentesis and other screening procedures has become accepted medical practice with very little public debate. As one David Smith, writing in the US, commented: 'The ease with which the abortion of Down's Syndrome foetuses is accepted as the best alternative even by people who otherwise oppose abortion, may be related to the conventional wisdom or popular misunderstanding of the level of mental retardation or other disabilities associated with this condition' (Smith, 1981). Another American author suggested, in this context, that Down's Syndrome 'is usually such a severe affliction that the decision of what to do about it is relatively straightforward' (Etzioni, 1973, p. 31). As you are aware, the exaggeration of the problems associated with Down's Syndrome is commonplace.

2.32 But in all cases of abortion following screening it is clear that handicapped foetuses are being treated in a highly special way. They are aborted not just because of the wishes and interests of the mother or parents but because of the character of the developing baby. The practice of aborting less-than-perfect foetuses is likely to affect attitudes to handicapped babies when they are born and as they grow and develop. As David Smith concluded:

> On the basis of diagnosis through amniocentesis, Down's Syndrome foetuses are being aborted solely because they have that condition . . . This issue may be even more complicated and controversial than that of paediatric euthanasia . . .
>
> When considering the use of amniocentesis and abortion it is important to examine whether or not Down's Syndrome is becoming the target of an entirely eliminative approach. The acceptance of a philosophy of elimination of Down's Syndrome through abortion might represent a backing away from the search for ameliorative measures. It might signal an abandonment of the investment of creativity in special education and training efforts in recent years. Most importantly it is crucial that a careful examination of this issue be undertaken to assure that either judgement or advice is being given potential parents out of the desire to prevent pain and suffering and not from the utilitarian desire to rid society of what are considered useless lives.
>
> (Smith, 1981, pp. 10–11)

2.33 There is a likelihood, too, that amniocentesis might be extended to more and more variations from the genetic norm. In his book, *The Prevention of Genetic Disease and Mental Retardation*, Milunsky (1975) made the following assertion:

> Endowed with four to eight deleterious genes, all individuals have reason to be concerned about their own health and that of their loved ones—both present and anticipated. Rare is the family that is entirely free of genetic disorder—however mild or insignificant—of genetic predilection, or of genetic–environmental effects. Almost 2000 autosomal dominant, recessive, and sex-linked

disorders have been catalogued. Not included are a large number of polygenically inherited disorders. Admissions to major children's hospitals in the developed countries indicate that 25 to 30 per cent have been for genetic disease, congenital malformations, and/or mental retardation.

Coronary artery disease (polygenic or autosomal dominant) is a major scourge; some 30 to 40 per cent of the population suffer from or eventually succumb to its effects.

(Milunsky, 1975, p. 1)

Will doctors decide that more of these should be categorized as disabling and recommend abortion?

Two court cases

2.34 The two cases involving these moral considerations which took place in 1981 were reported in *The Sunday Times*, whose reports are included below. After you have read them I will discuss some of the points they raise.

1 Alexandra

In the course of her short life, Alexandra has been through more legal processes than most people face in a lifetime. At the age of just 20 days, she has changed guardians four times because of fiercely contested court decisions. Each time her life has been at stake.

The argument which her case has highlighted has always been an emotive one: should a baby born handicapped be allowed to die, or must its life be preserved at all costs? What the Alexandra affair has shown, however, is that this issue, once decided privately between parents and doctors, is now a matter for outside intervention.

The battle over Alexandra's life began on July 28, the day she was born at Queen Charlotte's Hospital, London.

Day one Dr Robert Dinwiddie, the paediatric consultant in charge, informed Alexandra's parents that their baby was doubly handicapped: not only did she suffer from a blockage in the duodenum which, without an operation, meant she would soon die; but she was also a victim of Down's Syndrome, that is, she was a mongol. Pre-natal tests had failed to detect any genetical defect.

The parents refused consent for the operation that would save the baby's life.

Day two Dr Dinwiddie, plainly concerned about the decision, called in the social worker at the hospital for consultation.

Day three In a series of meetings with the doctor and social workers continuing into the following day, the parents remained adamant that they did not want their baby to have the operation. The assistant director of social services, Richard Jeffries, and his team from the Hammersmith local council referred the decision to their director, 36-year-old David Plank. Their unanimous advice was that the baby's life must be preserved.

Day four Hammersmith made Alexandra a ward of court, removing legal rights from her parents. 'It was a painful decision', said Plank. 'But I had no doubts and no regrets'. Within hours, he signed the consent order for the operation.

Day five Alexandra was transferred to Great Ormond Street Hospital for Sick Children, but the operation did not take place. The doctors there refused to carry out the operation against the parents' wishes.

Day eight David Plank learnt of the decision at Great Ormond Street and decided to act.

Day nine Hammersmith applied to the High Court for a judge to authorize the operation. Mr Justice Ewbank deferred full judgement on the baby's legal position for a further hearing in open court two days later.

Day eleven Ewbank, having heard representations from the parents, rescinded the wardship order, and Alexandra was back in the hands of her parents. The same afternoon, Hammersmith appealed against the morning's judgement and won. The wardship was reinstated and Alexandra was under the legal control of Hammersmith again. Meanwhile, Dr Dinwiddie informed the appeal court that he had found a colleague from Hammersmith Hospital willing to perform the operation.

Day twelve Alexandra, now back in Queen Charlotte's Hospital pending the court's decision, was moved to Hammersmith Hospital where the operation took place. The hospital said that it had been a success and that the baby was 'progressing well'.

(*The Sunday Times*, 16 August 1981)

2 John

How the 69-hour life of John Pearson put a doctor in the dock

by Oliver Gillie, medical correspondent

A DOCTOR accused of murdering a new-born mongol baby sat in the dock last week while evidence was given by former colleagues, doctors and nurses who attended the child during its short life and who have been granted immunity from prosecution. 'I am fully responsible, no one else. I do not want to be a martyr,' he is alleged to have told police.

John Pearson—the baby Dr Leonard Arthur is accused of murdering—died of broncho-pneumonia, an infection of the lung. The jury of six men and six women at Leicester Crown Court has to decide whether the broncho-pneumonia was brought on by a drug prescribed by the doctor or whether the baby would have got the lung infection anyway.

Arthur, 55, of Church Broughton, near Derby, has pleaded not guilty to the murder of the child, who lived for only 69 hours at Derby City Hospital. Police began investigations after they received information from Life, a pressure group opposed to abortion and euthanasia.

The evidence of two doctors and six nurses has outlined the events which occurred in the short life of John Pearson, who was denied food while in their care.

The baby was born on Saturday, June 28, last year at 7.55 am. He was slightly blue but soon became pink after oxygen was given. His heart, breathing, muscles and reflexes were all strong. He weighed a good 7¼ lb. Dr Robert McInnes, the paediatric house officer, noted shortly after the birth that the child had the mongol face and the single 'simian' crease in the palm of the hand characteristic of Down's Syndrome (mongolism).

Mongols often suffer from defects of heart or bowel that are not immediately apparent, the court heard. People with Down's Syndrome are seriously subnormal in intelligence and seldom able to live an independent life.

The mother, Molly Pearson, 31, was told of the mongol diagnosis by the obstetric house officer, Dr Thomas Fryatt, at about 9 am. A midwife held the baby beside her bed but she turned away and wept, saying: 'I don't want it.' She was more definite than most mothers in such a situation.

Dr Arthur confirmed the diagnosis at about 11.30 am and spoke to the parents. He then wrote in the notes: 'Parents do not wish it to survive. Nursing care only.'

Douglas Draycott QC, prosecuting, asked McInnes what this instruction meant. It meant that the baby should not be fed. Asked if there was any question of striving to keep the child alive, McInnes answered: 'At that point, no.'

Dr Fryatt said that he understood the instruction 'nursing care only' to mean keeping the baby warm, changing it, and comforting it. Asked why the word 'only' was used he said that it means if any other illness arises, such as broncho-pneumonia in this case, then it does not necessarily have to be treated. A midwifery sister with 11 years' experience, Kathleen Simpcox, who attended the baby, said she knew of no severely malformed child who survived after this instruction had been given at the hospital.

Dr Arthur prescribed the drug DF118 (dihydrocodeine) to be given to the baby every four hours. The drug is related to morphine but is not so strong. The baby had its first dose of the drug at about 2 pm on Saturday. At about 2.15 pm it was noticed to be going grey. The child became increasingly ill. That evening or the following Dr McInnes visited the ward and was told of the baby's condition but did not examine him.

By Sunday evening the baby was critically ill and considered near to death. The hospital chaplain was called and in the absence of the parents christened him John.

To Sister Cecelia Mahon the following evening the baby looked very poorly and distressed. His stomach and bladder were distended and not working properly. He was throwing back his arms in an attempt to get breath. Sister Mahon was asked by prosecuting counsel what she would normally do on seeing a baby

in this condition. She said she would telephone the doctor but because of the 'nursing only' instruction did not do so.

However, Nurse Margaret Slater obtained permission from the house doctor to give more drug and water through a stomach tube. The baby was given a full dose of five milligrams. Nurse Slater noticed that he then cried less and his breathing became easier.

A few hours later, at 5.10 am on the Tuesday morning, John Pearson died in Nurse Slater's arms. She blinked back tears as she told the court. Earlier Nurse Slater, who has two children of her own, one handicapped, had said that her job was to nurse the baby as she would her own child.

The court heard from two doctors in charge of the child that if antibiotics and oxygen had been given, as they would have been to a normal baby, then its life might have been saved.

(*The Sunday Times*, 18 October 1981)

During the course of Dr Arthur's trial the defence introduced evidence that after autopsy the baby had been shown to have brain, heart and lung damage and the prosecution was changed to 'attempted murder'. Dr Arthur was acquitted.

Doctor accused of murdering baby rejected by parents

The Guardian, *3 April 1981.*

20

DOCTOR CLEARED OF BABY'S DEATH

The Sun, *6 November 1981.*

Not euthanasia, but a case of extermination, judge says

Doctor who killed baby gaoled in Munich trial

From Hans-Ulrich Joerges in Munich

A Munich gynaecologist who admitted giving a lethal injection to a baby he considered deformed was sentenced yesterday to 2½ years' imprisonment for manslaughter.

But the court rejected a prosecution demand that the doctor, Willi Appel, aged 47, should be barred from practising for life.

The case arose from a Caesarean operation performed by Appel last April on a woman who was then about 34 weeks' pregnant. He told the court when the trial started on Monday that the baby, a girl, had a grossly deformed head and he had not expected her to live. He decided on the injection as "a release" after the baby survived for more than an hour.

His assistant, Eva-Maria Klotz, aged 29, who admitted filling the syringe, was given a 1½ year suspended sentence on the same charge. She was also ordered to pay a fine of 3,600 marks (£830) to a local children's home.

The two doctors, who listened impassively as the presiding judge passed sentence, were convicted of lesser-degree manslaughter. Normally manslaughter carries a sentence on between five and 15 years.

The case has attracted wide publicity in West Germany, where abortion has long been a controversial issue. Under existing legislation, which was opposed by the Roman Catholic Church, an abortion is possible on medical, social or psychiatric grounds until the end of the third month of pregnancy.

A medical expert told the court it was permissible to abort a deformed child until the end of the 24th week.

After that there had to be evidence that the child would not survive and that the mother was suffering mental stress.

Until his arrest, Appel ran one of Munich's biggest gynaecological practices. He testified that he was put under heavy pressure by the child's parents to carry out the operation after scanning tests indicated that its head was underdeveloped.

Appel, married, with twin daughters, said that despite his expectations the baby survived for 70 minutes after delivery.

Judge Raimund Kraemer, announcing the verdict, said the offence could not be seen as euthanasia but as a shattering case of the extermination of a life deemed to be unworthy of living.

Medical experts had told the court that the baby had microcephaly, a smaller head than average. But Judge Kraemer said the mentally handicapped could not be treated any differently at birth simply because they looked different. Reuter.

The Guardian, *30 January 1982.*

2.35 Ian Kennedy discussed the implications of the cases in *New Society* (Kennedy, 1982). He thought that the two cases were treated in a contradictory way and that the Dr Arthur trial had introduced new law about the crime of murder. The judge had:

> . . . indicated that it was lawful to treat a baby with a sedating drug and offer no further care by way of food or drugs or surgery, provided . . . first, that the child must be 'irreversibly disabled' and second, 'rejected by its parents' . . . The judge drew a distinction between (a) sedating the baby and then passively letting it die—'allowing nature to take its course'; and (b) doing a positive act to kill the baby—for example, giving it a death-dealing dose of drugs. The latter he said would be unlawful; the former lawful.
>
> (Kennedy, 1982)

But the ruling about baby Alexandra was in conflict with the outcome of the Arthur trial.

> In that case the baby girl was more severely disabled than the boy in the Arthur case. Besides being a Down's Syndrome child, she needed life-saving surgery. The parents indicated they did not want her to live, and doctors decided not to operate. The guidance of the courts was sought, and the Court of Appeal authorised the necessary surgery, despite the parents' wishes. *The Times* of 10 August said: 'It must almost inevitably be right for the court to come down on the side of life.' And in the Court of Appeal, Lord Justice Templeman stated: 'It was wrong that the child's life should be terminated because, in addition to being a mongol, she had another disability.'
>
> (Kennedy, 1982)

2.36 In Ian Kennedy's own view, 'the life of a child should not depend on whether its parents want it . . . it has never been part of our law or morality that parents may choose death for their children'. He drew attention too to the confusing reaction of doctors. At the trial they had uniformly spoken up in support of Dr Arthur's actions. Yet in response to a survey of consultant paediatricians and paediatric surgeons carried out for the BBC *Panorama* programme, doctors told a different story. Ian Kennedy described the results:

> [The BBC] sent out 600 questionnaires to British consultant paediatricians and paediatric surgeons. Dr Arthur himself is a senior consultant paediatrician. By 7 November, they had received 340 replies, of which 280 were fully completed.
>
> **What the doctors said**
>
> One of the questions was, 'A Down's Syndrome baby, otherwise healthy, requires only normal care to survive: Would you give it such care?' Two columns were provided for responses: one on the assumption that the parents wanted the child; the other that the parents rejected the child. Some 90 per cent of the doctors who responded on the basis of rejection by the parents, said that they *would* give normal care.
>
> Those who said they would not do so were invited to choose between four options: (a) to feed and care for it but not give it active medical treatment if it contracted a potentially fatal illness; (b) to give it drugs so that it was unlikely to demand food and would eventually die; (c) to give it a quick and painless death; (d) don't know. *All* of these respondents (8 per cent of the total, allowing for don't-knows) opted for option (a). None of them opted for (b).
>
> In the Arthur case, the child was an uncomplicated Down's Syndrome baby. Evidence appeared after postmortem that there was some damage to the child's heart, lungs and brain. But there is no evidence that this was known at the time Dr Arthur made his decision. Nor is it clear that the extent of the damage was incompatible with the baby's survival, all things being equal.
>
> Dr Arthur chose sedation and nursing care only—ie, option (b) of those listed in *Panorama's* poll. But *not one* of the doctors in the poll would have done what he did.
>
> So even if doctors were the arbiters of medical ethics—which I am convinced they are not—none of them in the sample regarded what was done as appropriate.
>
> (Kennedy, 1982)

2.37 Many doctors reacted to the two cases by arguing that decisions about handicapped babies should be left to doctors and parents, a view echoed by many parents of handicapped children including Claire Tomalin:

> I suspect it was an act of folly and real cruelty to put the parents in a position in which their painful and difficult private decision was overriden by a group of officials who could not know what it is to ponder such a choice in one's own mind for one's own flesh and blood, and who would not have to live with the consequences of their decision, but shuttle it off to someone else . . .
>
> One of the conditions of human life is our uncertainties about the outcome of our own decisions. Let us at least make them privately and peacefully and with people whose good will we can trust; and let us not hound and attack doctors or parents who reach their own decisions in pain and act upon them as they think best.
>
> (*The Times*, December 1981)

2.38 But the trial of Dr Arthur threw up an interesting contradiction: the judge was adamant that only those with no knowledge of handicapped children could be objective, though he did not see the implications this might have for the position of the doctor and parents in the case:

> The judge reminded the jury that at the outset of the trial he had asked if any of them had had dealings with handicapped children or if they belonged to any sort of society which concerned itself with the affairs of handicapped children. None of them had.
>
> 'That is of the greatest importance because it is vital that you approach your considerations of this case in a cool objective way. Strong feelings are of no help in this case. They should be eschewed and cut out,' he said.
>
> (*The Guardian*, 5 November 1981)

2.39 Others have argued that, since it is mothers who spend most time and effort looking after handicapped children, they alone should make the decision. When society does not provide adequate care and support for families with handicapped children, how can it be reasonable to expect mothers alone to take on this burden? Writing in *Spare Rib* Rose Shapiro criticized the organization Life for failing to take mothers' feelings into account:

> Life wants it to be an offence for any doctor to 'administer any drug or other treatment to a newly born child . . . with the intention of causing the death of that child', and to make it illegal to withhold treatment that could enable a newly born baby to survive. [Life] also suggests amendments to the Abortion Act, which would mean that foetal abnormality (either physical or mental) would no longer be grounds for abortion.
>
> They are determined to eradicate any kind of choice or discretion, whether it be that of a doctor, patient, or relative. They are not bothered about *how* decisions are made but want to stop them being made at all. Neither do they care about the lack of facilities and support that exist for people with handicaps and those who care for them, which must be one of the central questions involved in the decision to allow a severely handicapped child to die. Vague accusations about 'society's lack of compassion' are of no practical use to anyone, and ignore the contradictory feelings of a woman caring for a handicapped child 24 hours a day who finds this an intolerable burden but wants the best life possible for her child.
>
> (Shapiro, 1982)

2.40 I want to end this section with the words of two people: first Hannah Mussett, who has a daughter with Down's Syndrome. In her book, *The Untrodden Ways*, she described her feelings towards this child and her half-hearted attempts to kill her when she was a baby. But I have given the final word to Micheline Mason, herself severely physically handicapped, who was asked to react to Rose Shapiro's article.

> **The untrodden ways**
>
> Lucy is happy now, and should remain so while she is in a sympathetic environment, though my experience in the past has taught me how uncertain that can be.
>
> Does her present happiness justify her living? It must be weighed against the cost. The cost to Lucy herself in terms of past and possible future suffering, to

Martin [my husband], to me, to Julia [another daughter], and to society. The fears I had about the deleterious effect of such a child on parents and siblings were reasonable fears—and they have been realized. Show me a handicapped child, and I'll show you a handicapped family.

My reaction at the time of Lucy's birth cannot be dismissed simply as the effect of post-natal trauma. I had formulated my views about handicapped babies many years before. They were based on a life-time's loving observation of a handicapped sister, and a wide experience of teaching handicapped children. As the mother of such a child and of her sister, I have no reason to change my view.

The sentimental Victorian picture of a mother devoting her life exclusively to her crippled child is an appealing one, easily assimilated and recognizably one we are meant to applaud. But though the mother's action may be commendable as an exercise of Christian virtue, if it does not enable her son to live his life independent of her, to be lovable to others, to be accepted in society, then it is nothing. The most crippled bodies yet have an independent spirit, a need to be loved, and to identify with the community. And if her sacrifice is not too great for her to bear, it may well be for him, for his sister, for his father.

In Devon years ago, walking in the sandstone woodland, I heard an anguished cry—that same quality of sound that sends any mother rushing to protect her child, and later sent me to rescue Lucy from the cold—and when I searched the bracken I found a young rabbit caught in a gin-trap. The fur was torn back from shoulder and leg exposing bone and flesh, and it was panting in the hot sun, crying for relief. There was only one action to take—one which any responsible and humane person finding himself in that situation is obliged to take—and I knew it. I picked up a large lump of that beautiful red rock and held it suspended over its head, while the rabbit continued to cry. Compassion told me clearly what I had to do—but I could not do it.

That I failed to end the life of both the rabbit and Lucy is a measure of my weakness, not my virtue.

(Mussett, 1975, pp. 159–60)

Life: whose right to choose?

I do not want to discuss the issue. You are speaking about my life. You wish me to discuss whether or not, as a woman born with a 'severe' disability, I think I should have been murdered. It does not sound reactionary to me to hear of people who want to put an end to the killing of babies because they have disabilities. It sounds wonderful.

The Leonard Arthur case and its subsequent publicity in the media was very distressing to me and many of my friends with disabilities. We became afraid to turn on the TV or radio in case we were landed with another dose of 'Should we let them live?' When you already suspect the world would rather you weren't there, this sort of barrage can be most depressing. We felt the overall result was to legitimize and make respectable the most appalling aspects of our oppression. Strangely enough, what cheered me up was the realization that almost no-one I heard had any idea what they were talking about. It is always easier to deal with ignorance than with malevolence.

The medical profession sees the world through the most blinkered eyes. Their discussions about 'the quality of life' left me squirming. They are part of the establishment, dedicated to Law, Order and the State. They do not like 'misfits' who may not be able to earn their living or look beautiful, who will remind them that they cannot perform miracle cures like Jesus.

Doctors, parents, people in general are notoriously ignorant about disability. Hardly any of my able-bodied friends knew what 'spina bifida' or 'Down's Syndrome' meant. They, like everyone else, were caught up in the stereotyped images of helpless vegetables needing 24 hours a day care, slobbering, agonized, hopeless lumps of human flesh who ruin everybody else's life as well as their own. In fact, this is hardly ever true. It is people's fears of disability which are the problem.

These fears are fed mercilessly when the possibility of 'choice' arises. I do support the campaign for abortion to be freely available but I think it very naive to believe that any woman is free to 'choose' whether or not to give birth to, or keep alive, a baby with a disability, given the climate in which she is supposed to make that decision. All the pressure will be in the direction of abortion or killing the baby, when that baby—and not the society in which it and she will have to struggle—is seen as the problem.

Rose Shapiro wrote that 'Life do not care about the lack of facilities and support that exist for people with disabilities and those who care for them, which must be one of the central questions involved in the decision to allow a severely handicapped baby to die.' It's probably true that Life do not concern themselves with facilities for people with disabilities. But, on the other hand, how do you expect things to improve whilst you accept that another simpler solution lies in the murder of the seeming cause of the problem?

There are enough resources to support everyone in a comfortable, fulfilled life, whether they live in London and have spina bifida, or live in Bangladesh and are starving. It is the big illusion of our time that it is the resources that we lack. The problem is some people control them, misuse them, and deny them to the majority of the rest of the world.

I believe that women are being manipulated into believing that it is in their interests to destroy life because it may cause problems to society, rather than seeing that it is society causing the problems by standing in the way of their right to demand and receive the support they need to raise their children, regardless of their human condition—or even to hand over their children to others who have the personal resources they may feel they do not have.

Murder, masquerading under the euphemism of 'allow to die', can never be an answer to a human problem. What difference is there between this and Nazism? The Nazis started off their concentration camp techniques on people with mental disabilities, whom they called *unnutze esser* or 'useless eaters'. Rudolf Hess called this project *vernichtung lebersun werten lebens* ('the destruction of life not worthy of living'). Sounds familiar, doesn't it.

It is quite normal for some children to be born with disabilities. We are part of normal life. Until this simple fact is understood, accepted and reflected in the structures of our society, the arguments about 'quality of life' and so on are utterly misleading. We will be born, we will suffer, and some will sink and some will triumph. We will not go away. Nor will we stop shouting until the right to choose to live or die is ours, and ours alone.

(Mason, 1982)

3 *At risk of failure*

Who is at risk?

3.1 The approaches described in this section all involve the identification of a group of children who are thought to be at risk of educational failure because of their home circumstances or handicap or low educational attainment after entering school. The Bullock Report categorized such children as follows:

> There is ample evidence that children in poor socio-economic circumstances are more likely to experience difficulty in learning to read than those more fortunately placed. For a variety of reasons, some immigrant children are at risk. So are children with a family history of delay in learning to read or in speaking. Indeed any child who has shown significant delay in talking can be regarded as at risk in terms of reading and language development. Other relevant factors of a medical or neurodevelopmental kind are disturbances in auditory and visual perception, certain speech defects, fluctuations in mood and poorly coordinated movement.
>
> (DES, 1975, p. 246)

3.2 Since the 1960s, children thought to be 'disadvantaged' have been regarded as candidates for early intervention projects aimed at increasing their chances of educational success. Such measures have varied in scope from work with individual children and their families to projects aimed at the regeneration of a whole community's culture. They have varied, too, in the sophistication of their explanations for the origins of failure in school. 'Head Start' programmes in the US which sought to remedy the difficulties of black children in inner city schools were attacked as racialist for assuming that children's problems in school were attributable to deficiencies in the way their parents brought them

up. The British home visiting and community involvement schemes which grew out of the *ideas developed in education priority* areas can be seen to make a similar assumption.

3.3 There is no doubt that many parents have welcomed visits from home teachers or Portage visitors or their contact with toy library workers. But many, too, challenge the view that they need help in becoming better parents to their handicapped children. They may be overwhelmed by an abundance of advice, when what they ask for is practical assistance: babysitting so that the shopping can be done, the occasional night off duty so that they can get some sleep, short term foster care for the occasional weekend holiday. As early intervention schemes proliferate we have to ask, as always, how closely they are related to the needs and wishes of the people they are intended to serve.

The importance of early experience?

3.4 In Unit 8 Andrew Sutton drew attention to the fact that assumptions about the importance of early experience in determining later development had been incorporated in the Warnock Report without reference to the theoretical or empirical challenges to such views. In 1976, the Clarks had produced a book of empirical studies, *Early Experience: myth and evidence*, which they depicted as demonstrating a major reversal of orthodox opinion (Clark and Clark, 1976). In 1954 Gerth and Mills, in *Character and Social Structure*, had actually set out the *cultural* conditions which would tend to increase or decrease the effects of early experience. They claimed that the importance of early experience was not an immutable psychological fact, but would vary with the relevance of lessons learnt in the early years to the experiences of later life. It must vary too with the time when opportunities for gaining knowledge or mastering skills are made available. If, for example, space in the curriculum for learning to read was only provided in the infant school, the argument for the crucial importance of the years five to seven in the acquisition of reading skills tells us more about the organization of schools than the capacities of children.

3.5 'Get them early' has become a powerful cultural slogan which is unlikely to be reversed or modified by argument alone. As Will Swann made clear in Unit 12, there is no clear relationship between developments in psychological research and special educational treatment. This point is broadened in Unit 15 to apply to the whole area of special educational research. The issues which are selected or pursued by educational researchers may themselves be determined by the prevailing cultural view of what is important and therefore cannot provide an independent judgement. Research may legitimate current practice rather than initiate it.

3.6 In his prescription in 'Remedial education in the eighties', Charles Gains listed three '*new* directions remedial education might take in the years ahead'. These were 'early identification and treatment', 'remedial work across the curriculum' and 'institutional change'. About the first, he said, 'on the principle that prevention is better than cure, one can foresee that remedial ideas and techniques will progressively invade infant and nursery classrooms and, with the co-operation of parents, the home itself' (Gains, 1980, p. 8). In their report, *Child Guidance in the Eighties*, the Scottish principal educational psychologists argued that the 'general thrust' of research findings 'is towards early preventive intervention in the community and away from later palliative intervention in restricted situations'.

3.7 In the concluding part of this section I suggest that the idea that social and educational problems can be averted solely by action directed at individual children and their families at an early stage of the children's development is a prevention fantasy. It has emerged in response to a need for professionals and politicians 'to do something tomorrow'.

The adoption of early screening

3.8 Checklists intended to assess the attainment and behaviour of children in their first years of schooling are widely used as early screening procedures. As two of their main advocates have put it, such procedures 'are currently fashionable' (Wedell and Lindsay, 1980). In 1976, nearly half of the LEAs were using some form of early screening (Makins, 1976). The practice received support not only from the Warnock Report (DES, 1978), but

also from the Bullock Report (DES, 1975) and Court Report (DHSS, 1976). One of the principal recommendations of the Bullock Report, *A Language for Life*, was that 'local education authorities and schools should introduce early screening procedures to prevent cumulative language and reading failure and to guarantee individual diagnosis and treatment' (DES, 1975, p. 515). The Bullock Report related the use of screening procedures in education to those used in medical practice in a striking way. Chapter 17, which was devoted to 'Screening, diagnosis, and recording', opened with these words:

> Schools have long played a part in preventive and curative medicine for children by means of the School Health Service. We believe it is now time to introduce a far more systematic procedure for the prevention and cure of educational difficulties . . . 'Screening' is a concept drawn from the field of medicine . . . Translated into educational terms, screening implies the application of one or more procedures to a defined population of pupils, usually a whole age group, which would identify pupils likely to experience learning problems. This information would alert teachers to preventive action and indicate the need for further investigation in specific cases. Defined in this way screening is a process which would be applied at the beginning of the child's school life, before his growing involvement with the process of learning to read gives him an experience of failure.
>
> (DES, 1975, p. 245, paras 17.1–17.2)

3.9 General screening of the infant population is aimed at identifying a group of children 'at risk of failing'. It is:

> intended to indicate those children whose level of functioning, while not grossly impaired, is sufficiently below what is likely to be necessary for the normal sequence of development to take place. In other words, the children identified are at 'risk' in the sense that there is a probability that the children will fail.
>
> (Wedell and Lindsay, 1980, p. 130)

3.10 The Bullock Report was adamant that once the group at risk were identified they should receive additional help:

> the provision of special help should be an automatic sequel to a screening and diagnostic programme, and it should be given immediately to every child shown to be in need of it. Indeed, we believe it essential that a plan for subsequent action should be worked out in detail *before* any policy of screening is adopted.
>
> (DES, 1975, p. 246, para. 17.3).

3.11 In many local authorities the use of screening procedures has not been tied to specific intervention for all children at risk, but has been used instead as a sensitizing or alerting device, as a reason for giving such children detailed diagnostic testing, and as a prelude to referral to the school psychological service, sometimes with a view to later placement in a special school. Some local authorities, including Coventry and the London Borough of Croydon, have related the use of screening checklists to programmes of in-service education for teachers.

Buying the package

3.12 There are several screening checklists on the market. They are sold with handbooks explaining their administration and ethos, and sometimes include teaching suggestions for children who fare badly in specific areas. Geoff Lindsay (1979) investigated the use of a checklist which he has since produced commercially. This *Infant Rating Scale* has two versions, one for administering to children in their first term at school and a second for children at the end of their time in the infant school (see Figure 2 on the next page).

3.13 The Croydon checklist devised by Sheila Wolfendale and Trevor Bryans is described in their book, *Identification of Learning Difficulties* (Wolfendale and Bryans, 1979), and formed part of the evidence on which the Bullock committee made its recommendations. The checklist contains nineteen items requiring yes/no answers and is far less detailed than the *Infant Rating Scale*. I have reproduced the score sheet as Figure 3 and most of the items are self-explanatory. It is divided into four areas: 'speech/communication', 'perceptual motor', 'emotional/social' and 'response to learning situations'. There is also space for recording the assessment of reading age on the Neale standardized test. The authors argue that the in-service training of teachers is 'the single most important

LANGUAGE (cont.)

(ii) Receptive Language

(a) Comprehension of Instructions Can remember and follow instructions very well; will perform extended commands in the correct sequence (5 or more) 5	Above average ability to follow instructions (e.g. Get dressed, put your slippers in your bag, go back to class and get your milk) 4	Satisfactory (e.g. Put your book away, get a toy and play over there) 3	Will follow two simple instructions (e.g. Put your book away and get your milk) but often needs help 2	Only able to follow single instructions; confused by instructions to the class 1
(b) Understanding of Words Excellent understanding of vocabulary; comprehends many abstract and uncommon words (e.g. foal, beauty, happiness) 5	Good understanding of words appropriate to age, plus some higher level word meanings 4	Satisfactory 3	Does not understand many words relating to the classroom, or to activities and stories 2	Very immature level of understanding, (e.g. unable to name more than two colours) 1
(c) Memory for Oral Information Excellent memory; can recount past events in great detail and after a long period of time (3 months plus) 5	Above average memory for past and recent events (one month plus) 4	Satisfactory 3	Below average memory; retains simple ideas and procedures from day to day 2	Very poor memory; does not remember things from day to day 1

EARLY LEARNING

(i) Basic Skills

(a) Fine Coordination and Manipulation Excellent manipulation of pencils, crayons, building toys (e.g. Lego) 5	Above average control and coordination 4	Satisfactory 3	Awkward in fine control and manipulation 2	Very poor fine coordination and manipulation; great difficulties in holding pencils and brushes and manipulating small objects 1
(b) Drawing Excellent drawings; great deal of detail and imagination 5	Very good drawings (e.g. people have details such as fingers, eyes, and general shape is correct) 4	Satisfactory (e.g. match men with head) 3	Little detail, paintings limited to blobs of colour, people may be heads with limbs 2	Very poor drawings; generally unrecognisable, scribbles; very poor ability to draw between straight tramlines 1
(c) Writing Excellent writing ability (e.g. can write by self) 5	Can copy from the board and write on own, though has to ask for most words 4	Satisfactory. Can copy teacher's writing 3	Poor letter formation; needs to write over teacher's writing 2	Very poor writing. Cannot form letters, or write over teacher's writing 1
(d) Matching and Early Reading Excellent matching of words and can name many (20 to 30 or more) 5	Above average; matches words quite easily and can name a few (up to 20) 4	Satisfactory. Can match some words, able to match pictures 3	Below average; cannot match words alone, but can match pictures 2	Very poor matching; unable to match pictures 1
(e) Number Excellent number concepts; able to manipulate numbers and perform addition and subtraction to 20 5	Above average; can perform addition and subtraction to 10 4	Satisfactory (e.g. number skills to 5) 3	Counting limited to 5 2	Very poor conception of number (e.g. unable to count past 3) 1

Figure 2 An extract from the Infant Rating Scale: Level 1. Source: Lindsay (1981).

SPEECH/COMMUNICATION					PERCEPTUAL/MOTOR					EMOTIONAL/SOCIAL					RESPONSE TO LEARNING SITUATIONS				
1. Is the speech mainly free from infantile substitutions?	2. Retains and transmits simple messages.	3. Listens to stories with interest.	4. Organises thought to narrate experience.	5. Attempts to describe and discuss his environment.	6. Able to manipulate and understand the use of simple tools and constructional toys.	7. Draws/paints recognisable objects.	8. Can reproduce shape (a)	9. Can reproduce shape (b)	10. Can reproduce shape (c)	11. Receptive to new experiences.	12. Integrates easily with his peers in learning situations.	13. Forms appropriate relationships with his peers.	14. Forms appropriate relationships with his teachers.	15. Confident and self-sufficient.	16. Eager to learn.	17. Can persist at a task.	18. Can attend solely to the task in hand.	19. Given freedom of choice is able to pursue a learning task.	TOTAL NUMBER OF 'NO' ANSWERS

ENTER Y = YES N = NO

CHILD'S NAME	CHILD'S NUMBER	DATE OF BIRTH	DATE OF ENTRY	B or G	NEALE READING AGE
				N	

B or G
B = Boy
G = Girl

TEACHER'S COMMENTS

.....

.....

.....

.....

.....

Figure 3 London Borough of Croydon—checklist score sheet. Source: Wolfendale and Bryans (1979).

feature of an early identification programme'. They have produced three booklets containing suggestions for language development activities, for 'perceptual motor training' and for 'behaviour and learning management'. You may recall from Unit 5/6 that 'training visual perceptual skills does not improve reading scores', yet, remarkably, the assessment and training of perceptual/motor skills has persisted in the repertoire of educational psychologists. If tests had to have a certificate of usefulness as well as a requirement that they do what they say they can do, there might be very few tests left on the market. (*The Mental Measurements Year Book* (Buros, 1978) is a mine of information on the false claims of standardized tests.)

3.14 Most of those who have advocated early screening procedures also subscribe to the behaviourist approach to the teaching of basic skills:

> The interest in early education which has been generated by the concern with early identification has led teachers to take a much closer look at the specific steps the child takes in learning the three Rs. These steps should represent a sequence of teaching objectives which, if they are sufficiently clearly formulated, can form the most relevant yardstick for monitoring whether children are making normal progress, or whether they need extra help.
>
> (Wedell and Lindsay, 1980)

3.15 The current bibles for this group are Leach and Raybould (1977) and Ainscow and Tweddle (1979). Mel Ainscow is behind a direct attempt to produce an LEA-wide policy in Coventry which links the identification of learning problems to training teachers in the use of behavioural methods. He has produced a Special Needs Action Programme (SNAP), the first phase of which involves courses in dealing with learning difficulties for primary headteachers and special needs co-ordinators from each school. The participants of these courses will be expected to develop sequences of 'small steps' which can be specified as behavioural objectives in arithmetic, language, reading, social competence, spelling and writing. A basic skills checklist, which could be adapted, presumably, to reflect the idiosyncracies of the curriculum in each school, is used to determine the point in the curriculum sequence where those children who need additional help should start.

What's wrong with early screening?

3.16 Geoff Lindsay and Klaus Wedell have both been strong advocates of the use of early screening. In the foreword to a recent booklet on early intervention (Lindsay and Pearson, 1981), Klaus Wedell argued: 'Education authorities are rightly concerned to identify as early as possible those children who are not likely to make progress in school' (Wedell, 1981). However, in their joint paper they maintain that early identification procedures are often 'irrelevant', are of 'doubtful validity' and lead to 'uncertain prediction'. Some people have argued that identifying a group of children as 'at risk' may lead to a lowering of expectations about them and a feeling of helplessness on the part of teachers. Lindsay and Wedell claimed that teachers have 'reported that the checklists offered a useful framework for the normal assessment of children, and that this was in no way distorted by them. Nor, they felt, were their aims and teaching methods adversely affected' (Wedell and Lindsay, 1980). But in her investigation of the use of screening procedures in one LEA, Patricia Kenward reinforced the view that checklists are irrelevant: 'in the majority of cases . . . the problems of these children are already well known to the class teacher (and often the head teacher) before the screening procedure is operated, and . . . no new information is available as a result of completing the sheets' (Kenward, 1981). Look at Figures 2 and 3. What new knowledge could they give a teacher?

3.17 But there are also objections to the assumptions behind the use of screening procedures. They presume a view of classrooms in which a 'normal' education is provided which will inevitably fail to meet the needs of some pupils, who will, therefore, need to be picked out at a particular point in time for special treatment. Yet, if the normal classroom practice was flexible, mixed ability teaching, with recognition and support for children's difficulties as a natural part, then screening tests would be redundant. Screening procedures also focus attention on the difficulties of children rather than on those of the teachers or the curriculum or the organization of schools. You may recall the interchange between Anne, Sonia and Simon in Case study 30:

> *Simon* Haven't most British screening approaches tended to focus on doing something to the child?

Sonia That's too simplistic. Some have had a tremendous focus on the teacher; in-service training for example.

Anne They don't screen teachers and pick out the ones that are unlikely to help children develop their learning potential.

Sonia It'd be highly political to screen teachers.

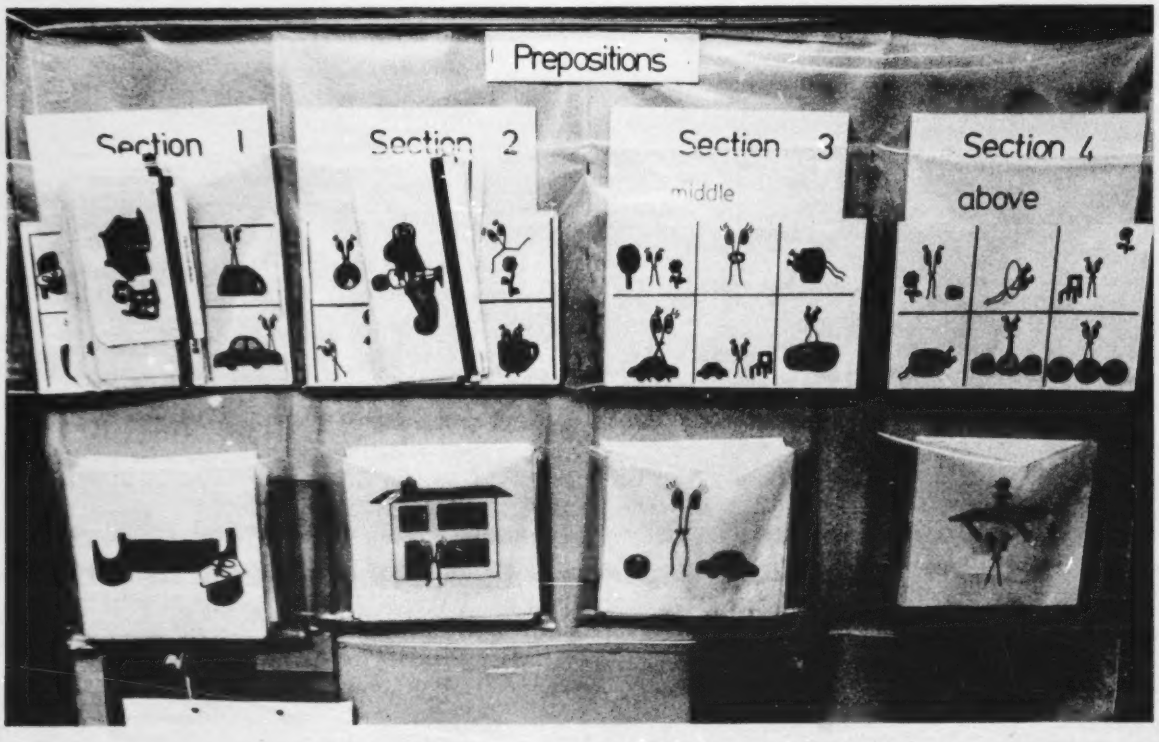
Simon It's highly political to screen children!

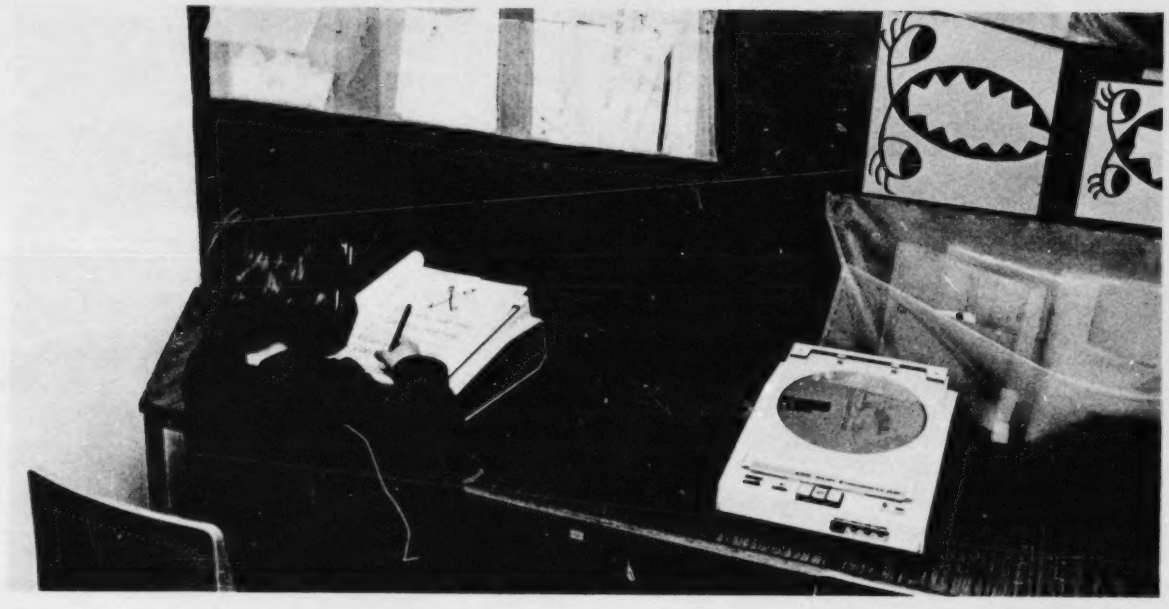
3.18 It would be as inadvisable and as negative an approach to education to produce screening instruments to pick out failing teachers as it is to pick out failing children. Schools need to be organized and resource materials and curricula developed so that all their participants can thrive. The Coventry approach can be seen as one way of focusing n the response of schools as a whole to pupils with learning difficulties. But I find its emphasis on specifying objectives for teaching problematic. What picture of schooling does it create? How would a curriculum of specified objectives fit into the work of a lively reception class? Are all the children to be taught in this carefully structured way? What effects will this have on their feeling of participation in class activities? Is this really the way children learn? Do children with learning difficulties all make progress in this incremental way or do some at least make sudden spurts forward? Does it ignore areas of particular interest to individual pupils? Does it ignore differences in approach and teaching style of teachers? In their book, Ainscow and Tweddle (1979) work out the ESN (M) school's curriculum in most detail, which they propose should be divided into a 'closed' section, the inculcation of facts and skills, and an 'open' section based on project work related to pupils' interests. Could this be transferred to the ordinary primary school?

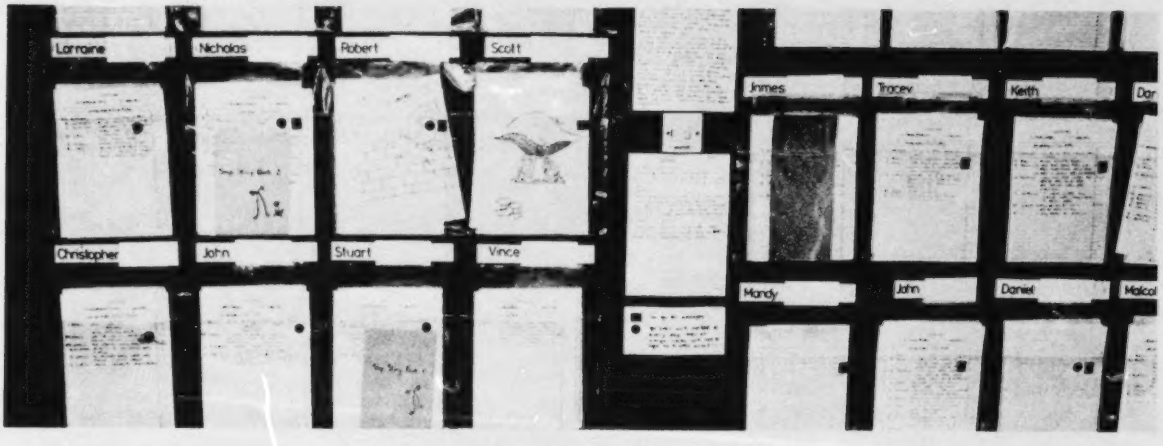
Westhall School for children with learning difficulties

Reading Now read Case study 45, 'Westhall School for children with learning difficulties', where Ainscow and Tweddle's ideas have been put into practice. It is hard to argue that such efforts are preventive for children who have already entered the special school, but the school has also developed a particular focus on working with pre-school children and children in primary schools to prevent their referral to special schools.

The structured curriculum in Westhall school.



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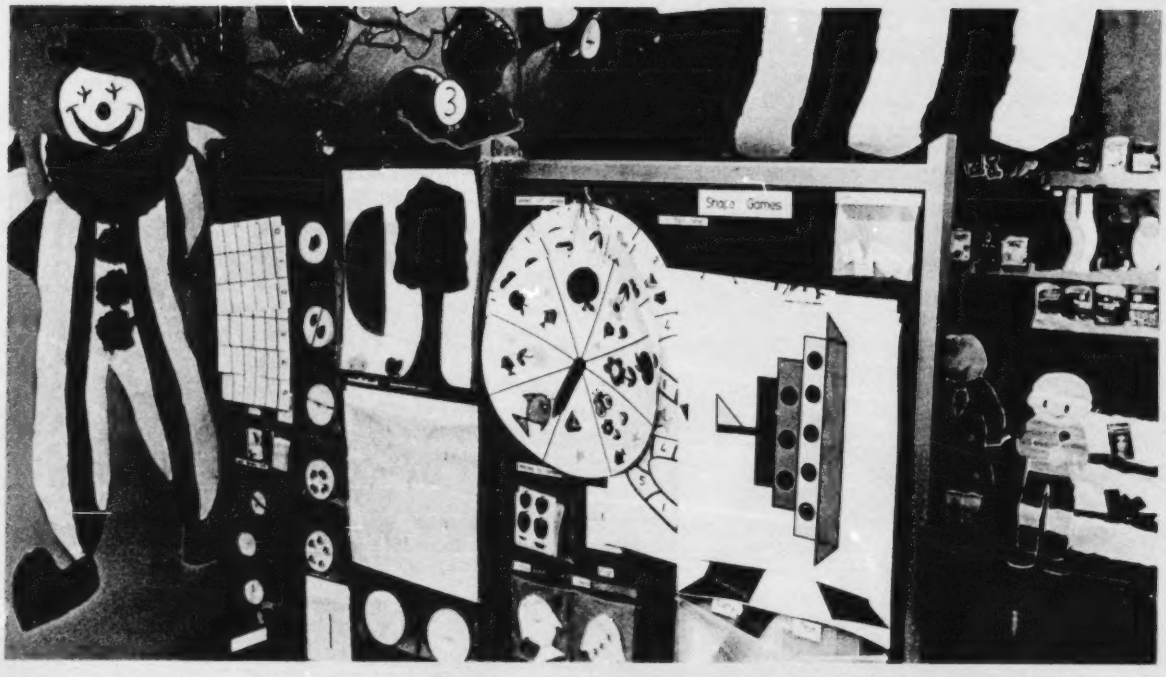

3
Space Games

3.19 Westhall's head thinks his school has a definite role in the prevention of learning problems: 'It's what you can do outside the school that really counts; so that you're actually using your resources to prevent children having the need to come to your school.'

The Portage project

3.20 Westhall operates one of the many home visiting schemes being developed around this country which are based on the developments in Portage, Wisconsin, initially described by David and Marsha Shearer (Shearer and Shearer 1972) and reviewed by Peter Wilcock (1981). Most involve work with pre-school children and have had their administrative bases in a variety of places.

3.21 The working hours of professionals as well as their views on the time required for teaching the children have led most such projects to concentrate their help on non-working mothers. Clearly this exerts an additional pressure on mothers of handicapped children to give up work or not to seek employment. It is not clear whether parents would prefer good part-time nursery provision, which involved them as well as their children, to membership of a Portage scheme. But it is certain that in the absence of such a choice many parents (usually mothers) do find the schemes enjoyable and beneficial.

3.22 Most schemes deliberately try to avoid the idea that a good visiting teacher must have massive qualifications or experience. Wessex has a scheme in which it was specified that pre-training should take no longer than a week. The emphasis is on helpers taking a supportive role and in turn reporting to others taking a supervisory role. In the case study, Bridget stressed the importance, for her, of the presence of specialists in her support group—a speech therapist and physiotherapist. There seems no reason in principle why parents should not provide this kind of support for each other. As they became more involved there is always the possibility that they might wish to develop forms of support which moved away from the original Portage approach introduced by the professionals.

3.23 David Thomas and Will Swann (Unit 3, pp. 26–7) describe contrasting approaches to support developed by groups of parents with handicapped children. 'Kith and kids', which employs its own professionals, emphasizes the development and teaching of skills much along the lines of the Portage scheme but without isolating it to single families. 'Contact-a-family', as its name implies, concentrates on sharing problems between families in similar situations, on the joint development of the services they need, and on concerted pressure to obtain services which they cannot provide from their own resources.

The service to neighbouring schools

3.24 The Westhall service to ordinary schools is also described in *Integration in Action* (Hegarty and Pocklington, 1982)—though in that study the school is called Greenfields. It contains a detailed description of the difference the Westhall support service made to Sheelagh. She was being considered for likely transfer to Westhall full-time because of difficulties in coping with her school's curriculum and, as the school stressed, because of her poor 'social development':

> Preliminary meetings between Sheelagh's teacher and the visiting teacher revealed differing interpretations of the root of the girl's learning difficulties. The class teacher's view was that Sheelagh's pronounced learning difficulties were such as to require constant one-to-one teaching, which she was unable to provide in a class of over 25 pupils. However, the visiting teacher felt that perhaps much of the difficulty stemmed from inappropriate programming. Referring to the Fletcher Maths scheme which the class were working on, he considered it was beyond Sheelagh's capability and 'totally unsuitable' in her case. A direct consequence was that she was forever demanding her teacher's attention. The visiting teacher noted that although 'there is a lot that Sheelagh can do, the school seems to want her removed because of the distraction she presents'. His immediate task was to provide work that Sheelagh could do by herself, thereby reducing the demands she made on her teacher.
>
> The specific programme of work that the two teachers agreed on was organized in such a way that the class teacher would need to spend very little extra time with the girl. Attention was paid to three areas: number, using cuisenaire rods and worksheets; language development and sequencing activities, using taped

The Winchester Portage scheme:

CHECKLIST NUMBER L 24 (component)

Child's Name MATTHEW

Home Teacher's Name MOLLIE

Week of March 16th

BEHAVIOUR: MATTHEW WILL REPEAT MOO, QUACK, WUFF IN IMITATION OF MOTHER WHEN SHOWN ANIMAL PICTURES

CRITERIA: 2/3

NUMBER OF: TIMES MATTHEW REPEATS MOO, QUACK, WUFF

		Tues	Wed	Thur	Fri	Sat	Sun	Mon	Tues
Wuff	3	⊘	⊘	✓	//	NOT PRACTISED AT WEEKEND - AWAY		✓	//
Quack	2	⊘	⊘	⊘	⊘			✓	✓
Moo	1	//	//	//	//			//	//

Days

DIRECTIONS: Use books which contain animal pictures including cows, ducks and dogs. Say "Let's find the _____ (name animal)". Point to the picture and say "There's the _____ (cow). The _____ says (moo-moo)". Repeat sound again.

REINFORCEMENT: If Matthew repeats correct sound say "Good boy. The _____ says _____"

CORRECTION PROCEDURE: If Matthew fails to repeat the sound, go close to his ear and repeat it. If necessary look into his face and repeat it again.

RECORD: // Matthew imitates sound in response to picture
/ Matthew imitates sound after additional cue
⊘ Matthew listens only.

A page from the language section of the Portage checklist. The behaviour being taught is production of a sound to identify an animal pictured on a card. On another chart (not shown here) the behaviour is broken down into a number of small steps. For each step the teacher prepares an activity chart. The teacher demonstrates the activity and then watches the mother carrying it out.

Mother and child carrying out the activity.

material plus pictures and worksheets; and logic and relationships, using logi-blocks and worksheets. All the learning materials had been prepared by staff of the special school and were mostly a self-contained package. They were accompanied by clear guides to content and method, thereby enabling a classroom ancillary to provide any individual attention that proved necessary. They were to be used at those periods of the day when the class teacher perceived that Sheelagh's inability to cope with school work caused her to present a significant management problem . . .

Weekly visits made by the teacher from Greenfields, each one of at least two hours duration, combined with the early success that Sheelagh was able to achieve working on these learning materials—'geared to give her total success'—led to a notable improvement in her social competence, attributable in part perhaps to an improvement in her self-esteem. In the few weeks remaining till the end of term it was unrealistic to expect any fundamental improvement in her level of attainment. However, one critical breakthrough was made: modification of the class teacher's attitude toward Sheelagh and her difficulties through a growing realization that her special needs *could* be met within the ordinary school.

One consequence of this change in attitude was the decision to postpone transfer to special school for a further term. Accordingly, Sheelagh moved up to a first year junior class where she continued to receive weekly attention from the specialist teacher. At the close of the school year the school's own view was that Sheelagh no longer needed such extensive support from the visiting teacher. Furthermore, any lingering doubts as to whether she should be transferred were finally dispelled.

(Hegarty and Pocklington, 1982, p. 265)

3.25 Hegarty and Pocklington stress the way the teaching of individual children on the scheme is used as a way to introduce broader changes in classroom and school practice; it becomes a form of in-service training. As Sheelagh's teacher remarked:

> Seeing the work which Sheelagh is capable of doing has helped me with other slow-learning children, and discussion of their needs has led to the preparation of special worksheets. The discussion which takes place about individual children's needs is always at a deeper and more effective level than general staffroom discussion—being able to observe and discuss others' methods in practice, with children one knows and can observe, reveals ideas for teaching strategies which one might not otherwise either have thought of, or have dared to try out.

Coventry has a scheme which also emphasizes in-service training, as did the approach to screening taken by Sheila Wolfendale and Trevor Bryans (1979). But if both aims, of selecting and supporting children and of training teachers, are to be successful, they have to be understood and agreed by the class teachers. In one of the supported schools the head viewed the support from Westhall as training for inexperienced members of her staff, while the teachers themselves saw it as relief and help for work with individual children. A compromise was achieved between the two schools, as expressed by the head of Westhall: 'We have ended up with the kids we want plus the members of staff [the head] was most concerned about' (Hegarty and Pocklington, 1982, p. 269).

3.26 Hegarty and Pocklington contrast Westhall's approach to supportive and preventive work with the work of some peripatetic remedial services:

> 1 The liaison programme operates from an increasingly well-stocked resource base—the special school—where the presence of pupils with a wide variety of learning difficulties, together with a team of teachers engaged in both curriculum development and class teaching, ensures the production and organization of learning materials *across the curriculum*. Remedial services by contrast tend to concentrate on one aspect of the curriculum, *viz* English, particularly the area of reading; also, they are not usually in a position to engage in curriculum development and tend to rely upon conventional learning resources.
>
> 2 The favourable staffing situation allows [Westhall] teachers to confine themselves to a maximum of two schools each. This enables them to provide an in-depth service and to continue to provide it for as long as considered necessary. Visits are on average of at least two hours' duration and may be for a half-day. The caseloads of many peripatetic remedial teachers are far too great to permit such levels of support. Some have as many as a hundred pupils on their

books and are confined to brief weekly visits at best. Many acknowledge these difficulties they work under and regret their inability to provide more intensive support and to maintain it over a longer period.

3 The priority is to identify children who are beginning to experience problems with their learning as early as possible in their school careers—'It's going down to the infant school and seeking to identify where you think they're failing.' Also, the introduction of more appropriate learning experiences within the infant school should prevent some learning difficulties developing in future as they will be dealt with at source.

4 The programme emphasises close contact and active working collaboration with ordinary teachers. Indeed its focus is on the class teacher and developing his or her skills rather than working directly with pupils. This again is problematic for peripatetic remedial teachers. However much they wish their work to be closely integrated with the work in the classroom, their teaching role predominates and there is often too little time for communication and consultation with the class teacher.

5 The liaison programme makes a significant contribution to in-service training. Class teachers are involved systematically in producing and carrying out programmes of work and in teaching—under supervision—pupils with learning difficulties. In this way, they acquire specific skills as well as a general competence in dealing with such pupils. In addition, class teachers are invited to [Westhall] for particular purposes, e.g. to experiment with preparing their own learning materials.

(Hegarty and Pocklington, 1982, pp. 275–6)

Breaking cycles of disadvantage?

The 1960s and 1970s witnessed the inception and growth of many projects intended to increase the opportunities of children so that they did not simply reproduce the disadvantages of their families. The assumption behind some of these was, apparently, that disadvantage was more palatable if it did not run in families, if 'cycles of disadvantage' could be broken. In the brief discussion which follows, I examine a scheme aimed at parents, a community involvement scheme, and the suggestion that education itself should be the means of creating 'fresh starts' for disadvantaged pupils.

Making better parents

3.27 Many home visiting schemes based in priority areas involve attempts to enhance the skills of parents within a single community. They differ in the extent to which they permit parents to take control of the scheme and to develop it in unforeseen ways. Some such projects attempt to 'regenerate' the political power of the community. Others provide facilities such as a neighbourhood family centre which remain of obvious use to the community without constant effort to recruit clients by the professionals involved. Some are open to the objection that the most immediately obvious beneficiaries in such schemes are the paid workers who run them.

3.28 The Lothian home visiting scheme, described by John Raven (1980), involved teachers based in nursery schools working as educational home visitors in an effort to reduce the gap between the school and community in the area:

> Each visitor has approximately 10–12 homes which she visits weekly, spending about an hour per week in each home. The remainder of the time is spent recording results, discussing findings with the evaluators, working in the nursery school or class, or in organizing parents' meetings and other activities designed to promote the growth of the mothers' feelings of motivation, confidence or competence and involvement in the formal school system.
>
> The visitor visits homes of children at the pre-school stage, i.e. between two and three years old. We felt this to be the optimum point of contact in that the educational relationship between the child and the mother would be unlikely to have crystallized. The child is young enough to adapt to a changed pattern of activity on the part of the mother, the mother not yet far enough into motherhood to be unable to reflect upon the quality of the interaction with her child.

The express purpose of visiting the home is to encourage and enhance the mother's unique and irreplaceable role in the educational development of her children. The visitors begin by working with the child but move as quickly as possible to an involvement of the mother in the activity. Quite often the mother expects the visitor to 'teach' her child and does not expect to be involved other than as an interested bystander. The visitors get over this problem in a number of ways:

- by structuring the activity to include the mother
- by encouraging the child to involve his mother
- by talking to the mother about her child, her home, and the activities of the visit
- by leaving books and other materials behind
- by discussing activities undertaken by the mother with the child between visits

The visitor normally takes with her some concrete object in order to give focus to the visit. Sand, water, coloured paper, building bricks, toys, playdough—anything in fact which will draw the attention of the child and mother. At the same time, however, the visitors are themselves encouraged to persuade the mother that any object, and any household activities—such as making beds, washing, hoovering, and ironing—can be used to focus the attention of her and her child.

The use of language plays a very important part. The mothers are encouraged to use language in such a way as to share meaning with their children, to collaborate in activity, to predict, to explain, to hypothesize and to test that hypothesis, to demonstrate causal relationships, and to stretch the imagination of the child. At the same time, however, mothers are encouraged to avoid too great concentration on such activity because it is taxing for both child and mother.

(Raven, 1980, pp. 12–13)

What view of the relative status and degree of knowledge of mother and helper is implied in this extract? The scheme was expected to have the following effects on the children, although measures of these were not obtained:

(a) an increase in IQ;

(b) an improvement in adjustment to school;

(c) a greater interest in books:

(d) a reduction in the need for remedial help in school.

3.29 As a result of the scheme parents appeared to be more interested in their children's schooling and some nursery schools increased their attempts to bring parents into the school. But, as Raven admitted, the scheme was designed to 'encourage parents to support what the school is doing rather than to give them any significant say in what the schools do'.

3.30 Some dangers were foreseen, among them that it might undermine the confidence of parents in their own methods of child-care, and that it might give them an unreasonable expectation of the power of schools to transform the lives of their children.

3.31 Other parental involvement schemes are less enthusiastic about professionalism in the realm of child-care, as they advocate the cause of mothers as the real experts here. Such schemes rely on informal methods of parent education, encourage community self-help in their implementation and are seldom explicitly compensatory. However, since they are based in deprived areas and use urban aid money, this is precisely what they are.

Reading Now read Appendix 1, a case study of a Scottish pre-school community project written by Jean Barr.

Comment The case study illustrates beautifully the hidden assumptions of parent involvement schemes, even those which claim to be least directive. The kind of community scheme described here has an attraction in that it does attempt to involve the parents, yet clearly they have little power to define its terms. In an area like this the needs of women may be apparently easy to identify and may be eloquently expressed by the women themselves.

But professional workers do not have the power nor are they paid to meet those needs. They are paid to do some particular thing tomorrow. And in defining the needs of the families, in believing that they are meeting their needs and in disseminating this belief, they obscure the women's testimony.

Can education compensate for society?

3.32 In his review of early intervention schemes in the US, Uri Bronfenbrenner (1974) argued that:

> The first and most essential requirement is to provide those conditions which are necessary for life and for the family to function as a child-rearing system. These include adequate health care, nutrition, housing, employment, and opportunity and status for parenthood. These are precisely the conditions that are absent for millions of disadvantaged families in our country.

In the absence of such social reconstruction is it possible for intervention schemes to alter the lives of children?

Reading Now read 'Education can compensate' by A. H. Halsey, Reading 5.4 in the Reader (p. 353 ff).

Comment Halsey describes the conclusion of the EPA projects and the long-term follow up of the 'best' early intervention schemes in the US, both of which emphasized the positive contribution early education can make to the educational progress of children. Clearly children can be affected by interesting and continuous educational experiences. The results of these studies are in marked contrast to the results of the early Head Start programmes, some of which aimed to show that a summer education scheme run by volunteers might have lasting educational benefits. But the assumptions behind these studies can be called into question. Is the early education the children receive somehow taking the place of parental interest or could it instead be a substitute for the otherwise mediocre education these children receive in school? And should the discovery that some forms of education can improve the attainment of some poor children lessen in any way our resolve to reduce poverty or poor housing? Could improving a child's reading age be regarded as compensation for the circumstances of her family? Could it be that a change in circumstance might do more for her education than early intervention by professionals? And if compensatory education does nothing to reduce the numbers of poor, badly housed or unemployed people, what is it for? That is a question to which I will return at the end of this unit.

Early intervention: reality or fantasy?

3.33 The production of failure or disaffection or handicap involves complex interactions between people, their families, their schools and communities under the controlling influence of political and economic processes. Now in some ways it is rather irritating that this should be so. The idea that a problem should have a simple cause, the discovery of which would lead to its solution is an attractive, seductive notion both to some professionals as well as some politicians. The prevention fantasy, that complex human problems can be solved by a simple technique discovered by the heroic efforts of one person or research team, is not uncommon. Such delusions reached their height of absurdity in the early Head Start programmes and the contradiction between such practices and the reality of the problems of American inner cities can only be explained in terms of ideology. Simplistic approaches to prevention generally rest on the power of a medical image of cause and cure, as in the rare success in the treatment of phenylketonurea. While the Head Start programmes may not have been discussed in medical terms, the efficacy of screening procedures for initiating a programme for the prevention of illiteracy certainly were.

3.34 A few years ago people became attracted to the idea that some of the problems in the relationship between mothers and their children might be attributable to a few missed magic moments shortly after the birth of a baby. Martin Richards described research on early separation and 'bonding' in an article for *New Scientist* in 1974:

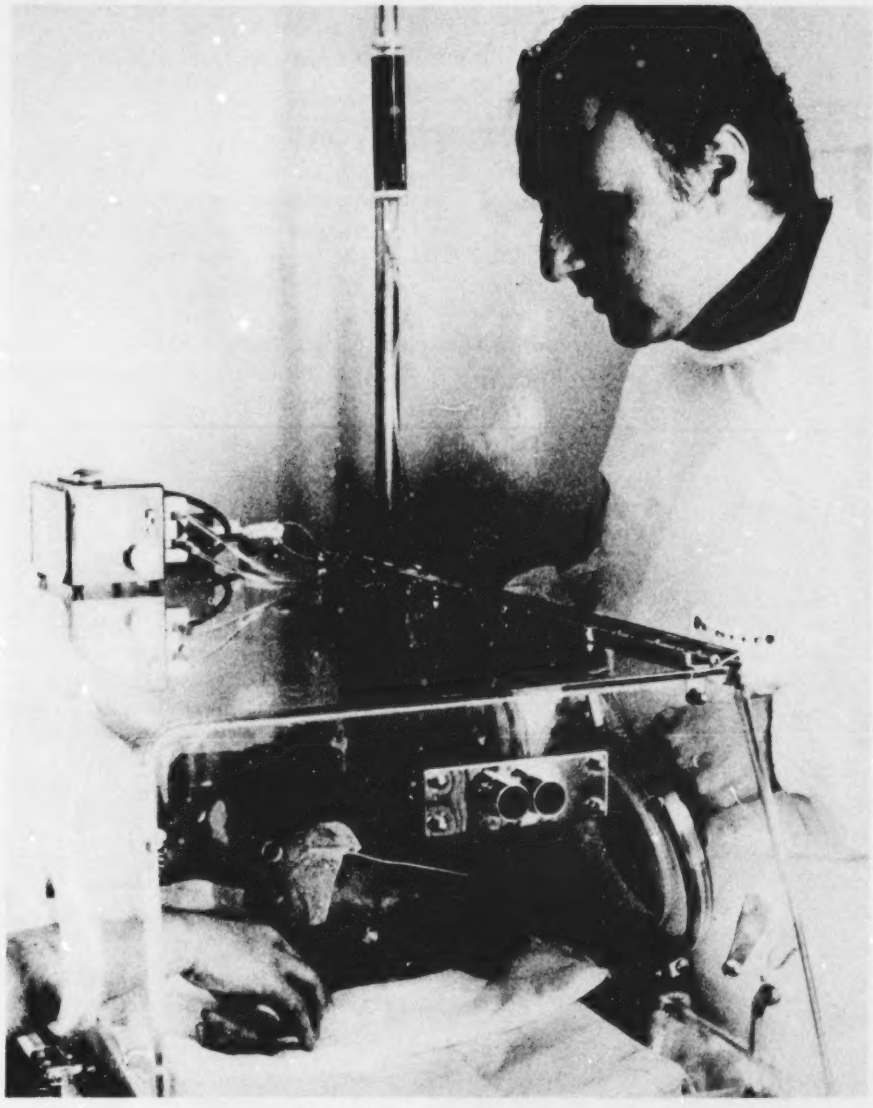
> **The one-day-old deprived child**
>
> Problems of maternal deprivation in two-year-old infants are well known. But current research at Cambridge University suggests that separation of mother from child within hours of birth can have long-term effects on the social development of the child.
>
> (Richards, 1974)

3.35 The article referred to the work of two paediatricians in the US—Professors Klaus and Kennell. In *Maternal Infant Bonding*, they had outlined a number of 'mothering disorders,' 'ranging from mild anxiety, such as persistent concerns about a baby after a minor problem that has been completely resolved in the nursery, to the most severe manifestation—the battered child syndrome'. They also included 'disturbed mother–child relations' and 'behavioural problems in adopted children'. All these problems, they maintained, could be attributed to a disruption of bonding: 'It is our hypothesis that this entire range of problems may result largely from separation and other unusual circumstances which occur in the early new-born period as a consequence of present hospital care policies' (Klaus and Kennell, 1976, p. 14). Some of their research was based on work with black mothers in an inner city area, and they claimed that, as a result of a brief period of humanity shown to them by the personnel in the hospital, they were able to relate to their children better and that their children were also more highly developed in the first year than a control group (in Richards, 1974, p. 820). As you probably know, the importance of bonding has become part of the new orthodoxy of early child-care along with breast feeding, a pressure which itself may contribute to a feeling of inadequacy in those who don't wish to or can't live up to someone else's definition of normality. *The Daily Telegraph* proclaimed the wonders of this 'new' discovery:

> A seemingly small but potentially life saving section was added recently to the training syllabus of student midwives. It is the tuition of bonding—that marvellous and still mysterious creation and cementing of attachment between a mother and her newborn, within, ideally, the first minutes of a baby's life . . .
>
> A premature or sick baby can be helped to health by this invisible bonding. And a malformed baby can be accepted and cherished if the bonding is skilfully handled and the parents encouraged to remain in close contact with their newborn as soon and as much as possible.
>
> Perhaps if mongol baby John Pearson had been cuddled and nursed by his mother or father in the first few moments of his short sad life he might have stood a better chance of living.
>
> (*The Daily Telegraph*, 6 November 1981)

3.36 But there are several consequences of reducing the establishment of a relationship between parents and children to the skilful handling of bonding. I have mentioned the feelings of inadequacy it may provoke in some mothers and fathers. It also singles out a very brief period from the whole process of having a baby in hospital, which can be a dehumanizing and unpleasant experience. Women are treated as if they were sick bodies instead of healthy people by doctors who often show little concern for their sensitivities or wishes. The critique of medical practice either before or after the birth of a child should not depend on the discovery that consideration of mothers' feelings boosts infant IQ or the rate of weight gain. Picking out the encouragement of bonding for special treatment limits the range of criticism. It is confined to a few minutes after birth, rather than taking in the whole treatment of mothers-to-be by doctors, the whole area of doctor–patient relationships, and the responsiveness of hospitals to the needs of their clients.

3.37 But most damaging of all is the deception that over-simplifications involve. They reduce solutions to a wide range of problems to a single medical-style intervention. The identification of bonding difficulties of inner-city black mothers, like dispensing compensatory education, deflects attention from inadequate material conditions.



Special care baby.

A perfect start.

4 *Pupils with learning difficulties in Scotland*

4.1 The recent changes which have been taking place in the education of pupils with learning difficulties in Scotland are part of a co-ordinated national attempt to alter the curriculum and organization of the schools and the nature of remedial provision within them. Television programme 7 and section 4 of Unit 13 link efforts to make curricula relevant and appropriate for all pupils to the issue of disaffection among pupils. Unit 13 mentions a document produced by the Scottish inspectorate (Scottish Education Department, 1978), which suggested that the curriculum was the major cause of learning problems and hence their 'cure' or prevention had to involve a reappraisal and revision of the curriculum (Unit 13, para. 4.7). In contrast, then, to many early screening schemes, the whole school rather than the individual pupil is seen as the starting point for the prevention of learning problems. A child has a learning problem when her educational needs are unmet, not because she displays a 'low' ability.

The background to the changes

4.2 In examining the special educational system in Norway for Unit 10 I noted that there were affinities between the educational systems of Scotland and Norway. In Scotland, there is a higher degree of *de facto* centralization of curriculum and school organization than in the rest of the UK:

> The curriculum, if not controlled, is strongly influenced by central development . . . There is a central committee on the curriculum which initiates curricular development through various subject committees and working parties. The existence of a cohesive college of education system—where all teacher training is undertaken—also serves as a strong influence on uniformity of development . . . [add] to this the supervisory role of the Scottish Education Department and its inspectorate in a much more closely-knit educational community.
>
> (Jones, 1979, pp. 59–60)

As an outsider to Scottish education, I found the strength of the informal links between the inspectorate, the LEA administrative staff and the staff within the schools and colleges quite striking. Within the LEAs, I was also struck by how deeply and practically involved the administrators were in educational developments in their areas. One factor which decreases the distance of schools from the LEA administration is the absence of school governors, although whether their absence is a good thing or not is another matter.

4.3 The changes that have been proposed and to some extent developed reflect two sets of criticisms. The first is related to a general disappointment with how little comprehensive schools have adapted to the differences in interests and capacities of all their pupils; the second is more specifically concerned with the way traditional forms of remedial education have responded to the casualties of an inflexible education system. While comprehensive schools were intended to provide an education that was different in both form, content and method to the selective system's, very often they simply aped the grammar schools they replaced. Many of them, in offering 'a grammar school for all', emphasized the failure of those whose future after school could not be encompassed within academic aspirations. Howell Jones commented that 'the real problems' faced by comprehensive schools 'are not those associated with able, well motivated, examination-oriented youngsters, but those concerned with the effective teaching of the slow learners and children with learning difficulties' (Jones, 1979, p. 61). Criticisms of the Scottish education system have linked the two parts of this comment: children have learning difficulties in schools because schools are dominated by values which define success in terms of good results in academic examinations open to relatively few pupils.

4.4 There have been key differences in the ways in which comprehensive schools have developed in England, Wales and Scotland in the sixties and seventies. In England in the fifties, grammar school places were available for about 20 per cent of the school population, compared to 35 per cent in Scotland, whose pupils, incidentally, transferred to secondary schools at 12 rather than 11 (and still do). And in rural areas of Scotland, there has been a continuous tradition of education for all pupils under one roof, even if this did involve rigid streaming within the school. These 'multilateral' schools provided

'one of the models for the new comprehensives elsewhere in Britain', though the multilaterals were adopted elsewhere in the UK only on a limited scale and often only temporarily (Bell and Grant, 1979). As early as 1947, a report of the Advisory Council on Education in Scotland had said that comprehensive schools were 'the natural way for a democracy to order the post-primary schooling of a given area' (Scottish Education Department, 1947, para. 164). In some areas and among some sections of the population in Scotland, then, there has been a longer and stronger comprehensive tradition than in England, but it would be a mistake to see this as universally welcomed. According to Robert Bell and Nigel Grant:

> It has become almost unthinkable for professional families in Edinburgh to send their children to anything but a fee-paying school of some kind and the middle classes of the four Scottish cities have actually opted out of free local authority education on a scale unknown even in south-east England.
>
> (Bell and Grant, 1979, p. 68)

In England it became impossible for parents to buy a place for their children at local authority grammar schools after 1945, but this practice continued in Scotland until the early seventies.

4.5 Four reports appeared in the period 1977–8 which, to different extents, emphasized the need for revision in the Scottish curriculum, particularly at secondary level. The Pack Report, *Truancy and Indiscipline in Schools in Scotland* (Scottish Education Department, 1977c), for the most part interpreted the difficulties of pupils and their solution in a traditional way in terms of the deficiencies of individuals and the provision of guidance or treatment to help them overcome their problems, and this view was strongly dissented from by one member of the committee (Demarco, 1977). However, the committee were 'in no doubt that a clear relationship exists between the provision for a pupil and his attitude to school', and they called for 'significant changes in the approach to the curriculum [which failed] to satisfy the needs of many of the pupils involved' (Scottish Education Department, 1977c, pp. 76 and 120). The Munn Report (Scottish Education Department, 1977b) was primarily concerned with the curriculum in the last two years of compulsory schooling but felt this should be based on mixed ability work in the previous two years with a common course throughout Scottish schools. They argued for three levels of the curriculum in the next two years of schooling, and a further document, the Dunning Report (Scottish Education Department, 1977a), described the way these levels might be assessed: its title was *Assessment for All*, but it did not advocate one assessment (or no assessment) for all (see Nuttall, 1982, for the fate of DES moves towards a common examination system). The Munn Report said the first priority was to change the curriculum for pupils with learning difficulties: 'if priorities in planning have to be determined, we believe that the needs of the pupils in the lower ability ranges should be given pride of place' (Scottish Education Department, 1977b, para. 11.7).

4.6 The Pack, Munn and Dunning reports were concerned only tangentially with learning difficulties, but in 1978 HMI issued a progress report, *The Education of Pupils with Learning Difficulties in Primary and Secondary Schools in Scotland* (Scottish Education Department, 1978). Within this report, the inspectorate heavily criticized the bulk of existing remedial provision and argued for a radical rethinking of it. They based their arguments on a survey of the work in schools (they visited 140 primary and 39 secondary schools). They identified 'key issues' around which discussion about new developments might range and outlined the new roles that might be required of remedial specialists, principal remedial teachers, heads, LEA administrators, curriculum specialists and the colleges of education. Their document can be seen as an attempt to restructure the approach taken by schools by viewing their curricula through the eyes of those whose needs they met least well.

The critique of remedial education

4.7 In the last section I included a quotation from *Integration in Action* (Hegarty and Pocklington, 1982) to show how far Westhall School's support scheme countered the criticisms of peripatetic remedial education. The case studies on Chalkway School (Case study 33) and Bridgewater Hall (Case study 42) also contain criticisms of the existence of remedial classes within schools (see Unit 5/6). The rigid separation of remedial classes

from most or all of the curriculum of the rest of the school is open to obvious objections. The pupils within them may be provided with a restricted, different education. They lose contact with the academic and social life of the rest of the school and their transfer back into mainstream classes may become increasingly difficult. Such provision leaves unchecked the deficiencies in the school curriculum which failed to match the needs of the pupils. Although withdrawing children from ordinary classes for a few sessions a week overcomes some of these problems, this practice may still leave the general curriculum untouched and create problems of how what is learnt in withdrawal lessons is co-ordinated with and transferred to mainstream lessons. Even where remedial specialists are trying to make the whole school respond to pupils with learning difficulties, they are often hampered by their own lack of status and power and by the fact that the head and other staff may not see the adaptation of the curriculum to the needs of the less academically interested as a high priority. The proposals in the inspectors' progress report were an attempt to overcome all these problems (Scottish Education Department, 1978). Figure 4 represents the arguments for and against provision outside the classroom.

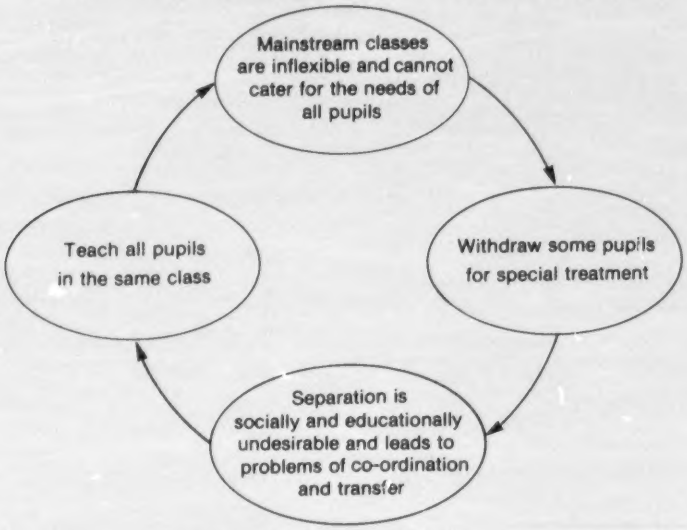

Mainstream classes are inflexible and cannot cater for the needs of all pupils
Withdraw some pupils for special treatment
Separation is socially and educationally undesirable and leads to problems of co-ordination and transfer
Teach all pupils in the same class

Figure 4 The remedial cycle.

4.8 Any alternative arrangement for special provision has to attempt to break this cycle. The 'package deal' associated with many screening procedures can be seen as one attempt to enable teachers to cope with diverse talents within a single room by introducing pre-planned individually structured curricula. The Scottish initiative has attempted to increase the flexibility of the curriculum and classroom teaching by the twin approach of curriculum preparation and development and team teaching.

4.9 The inspectors' progress report identified a number of areas for reform (all page numbers refer to the report: Scottish Education Department, 1978):

(a) Remedial education was to be given *a wider definition*. It was to include all children who experienced a difficulty with their education, however temporary or transient or whatever the cause. The inspectors thought this might involve 50 per cent of the total school population.

(b) The report argued that 'because the range of learning difficulties is so wide and their nature so complex . . . remedial education is a responsibility of the whole school' (p. 22).

(c) Assessment was to be related closely to the capacities of the pupils: 'Just as the curricular demands made on pupils should match their potential, so assessment should match their capabilities' (p. 23).

(d) Remedial education was to extend across the whole curriculum. While the 'learning difficulties of many pupils' were seen 'to stem from the fact that they [were] having to tackle work which [was] not suitable for them', this was not to be solved by offering them a restricted curriculum which might lead to a 'sense of failure', 'boredom' or even 'complete rejection of what the school has to offer'.

(e) The methods employed in mixed ability classrooms had to be developed and extended so that all pupils were included in class work.

(f) Remedial education was to be organized on the basis of minimum withdrawal from ordinary lessons. Where possible remedial staff were to work alongside class teachers.

(g) Special attention was to be paid to the transition from primary to secondary school, which was seen as a period when children were especially vulnerable.

4.10 The implementation of these changes required considerable adaptation in the working lives of many people but above all in the jobs of remedial teachers. Not only were they to see and teach some children individually or in groups but they were to act as consultants to other members of staff over individual children, teaching methods and resources; they were to have an overview of the whole curriculum within the school, especially the language used; they were to be responsible for re-introducing children from special segregated provision into school and for providing intensive English courses for non-English speakers; they were to be experts in observing and assessing children's learning difficulties; they were to work co-operatively in the classroom with class teachers in primary schools and subject specialists in the secondary school. Some were to be on the staff of both primary and secondary schools to ensure educational continuity. For each group of remedial teachers working within a comprehensive school and its group of 'feeder' primary schools, there was to be a principal remedial teacher with responsibility for co-ordinating and supporting the team, gaining the co-operation and involvement of subject specialists and contributing to local authority policy development.

4.11 It was to be 'the responsibility of the head teacher to ensure that a policy of help and support of pupils with learning difficulties is planned on a whole-school basis'. Remedial advisers within the LEA were to have a similar relationship to their colleagues in the advisory service to that between remedial teachers and subject specialists in the secondary school. Finally, a senior member of the LEA administration was to have overall responsibility for shaping the policy in her area and ensuring that remedial staff were appointed to those schools with the greatest need. A new form of training would be required for the new breed of remedial specialist which would provide the 'sustained study in depth which will persuade teachers that the "remedial specialist" possesses an expertise over and beyond that of dealing with early difficulties in reading and counting'. The role of parents in these developments is left to the end of the report and their 'understanding and support' is to be 'enlisted' and 'revived' if it 'flags'. It seems that parents are not seen to be near the centre of the educational stage.

Theory into practice

4.12 In response to the comprehensive nature of the reforms and the huge list of responsibilities and skills to be expected of remedial specialists, one adviser for English asked:

> Where are they all? The ordinary-looking teachers who will disappear into the remedial base, spin round and emerge from the ball of light, garishly costumed, thighs bared, all set to be tutors, monitors, co-operative partners, diagnosticians, healers, tacticians, consultants and experts in language and learning. Where is wonderteacher, without whose timely intervention learning difficulties will gain control of the world?
>
> (Lamont, 1981, p. 6)

4.13 But the HMI report had not appeared out of the blue. Based as it was on a survey of existing practice and consultation with practitioners, it can be viewed as an attempt to define and disseminate good practice.

4.14 As one teacher remarked:

> The inspectorate's report gives remedial teachers what they had long sought—a clear identity for their discipline and definite roles for those who practise it. It recognized as valid the belief that all teachers are remedial teachers, [and] queried wholesale extraction methods and separate classes. It stated a new concept of remedial education based on the multi-purpose role of the specialist in learning difficulties. It provided an opportunity which, if taken by teachers and the local authorities, could mean remedial education's coming of age.
>
> (Frank Devine, principal teacher, special services, Westerhales; personal communication)

When it appeared, some local authorities, such as Grampian, had already formulated plans for reshaping remedial education. Others, such as Fife, Strathclyde and Lothian, used the weight of the report for pushing forward local initiatives. In the Fife region they responded to the report in an 'unprecedented manner'. As the depute director of education put it, 'Instead of debating its contents we decided to work out how to do something about it.' They set out annual targets for its implementation and established curriculum committees in the schools. By August 1981, they had abolished all separate remedial classes. They held area discussions with subject specialists and by August 1982 aimed to have evolved a scheme to reduce the numbers of teachers for the first years of secondary school, to increase the amount of block timetabling and to enhance the emphasis on project work in the schools. They also responded to the inspectorate's report by seconding teachers for training on diploma courses in 'pupils with learning difficulties'.

The changes in Grampian

4.15 The formulation of the remedial policy in Grampian took place at the time when the inspectorate were surveying remedial provision and was a major influence on the strategy described in its report. The Grampian regional council was formed in 1975 and immediately after this a survey of remedial education was undertaken in primary schools and a working party was set up to look at remedial education in secondary schools. Both the child guidance service and the LEA administration were heavily involved in the early definition of policy, but Bill Fordyce, the depute director for secondary education, had overall responsibility for setting up the working party, chairing it, overseeing the consultation process which followed the publication of the report (Grampian Regional Council, 1977), and explaining the proposals to the education committee and persuading them to accept them. Over several years he devoted 40 per cent of his time specifically to the development of remedial policy and welcomed the degree of involvement. As he remarked, 'I suppose fundamentally I'm classified as "an educational administrator". In my book the emphasis is on the first word, not the second. The second is a necessary evil.' He felt that it was an appropriate part of his job to help to initiate and guide a region-wide policy, as he said when interviewed:

> You have to get a balance between doing nothing and being over prescriptive. But I have no doubt that it's my job as an official to make recommendations to the education committee after appropriate consultation and then produce broad policy guidelines. Remedial education is a good example. Within certain guidelines you are free to exercise your own professional judgement but there are certain things you must not do, you must not have a separate class for remedial youngsters.

4.16 The working party was determined to move away from a traditional approach to remedial education towards an emphasis on the total curriculum, to concentrate on the problem of transfer between primary and secondary school and to shift towards team or 'co-operative' teaching. They planned to organize remedial work through area teams under the general direction of the child guidance service:

> We decided that a group of remedial teachers should work together as a team in an area consisting of a secondary school and its associated primaries. We arranged a meeting between the head teachers of these schools to discuss the provision they made for remedial education at present and how they would have to change in light of the committee's policy decisions. Then we had a meeting with the area remedial teachers and talked to them about how their methods of work would have to change . . . We recruited a principal remedial teacher to act as the leader of the area team and we recommended that they hold team meetings once a fortnight. To a great extent the development of an individual team depends on its group members and most importantly on the leadership of the principle remedial teacher.

4.17 The changes were easier to accept because they were associated with a considerable increase in remedial teachers, equipment and materials. They asked the education committee to double the numbers of remedial teachers from 160 to 320. The committee agreed but as pressures for education cuts increased sixty of the posts were frozen. However, the remaining remedial staff were 'taken out of the red list'; they were not susceptible to further reduction. Bill Fordyce was unconvinced that change could only

take place when financial circumstances are favourable:

> I don't think it really matters whether the financial cake is expanding or shrinking. It is still necessary to make priority decisions about where the money is going to be spent. The education committee recognized that some youngsters have difficulty in learning, that it is part of the responsibility of schools to minimize these difficulties and that the best way to do that was to provide additional finance.

4.18 Remedial teachers were recruited from experienced primary and secondary teachers:

> There's no point in imagining you can take a student from a college of education and turn them into a remedial teacher. We looked for experience and also for teachers who were above average and who would get satisfaction from always working with youngsters with learning difficulties; that's asking a lot of people.

4.19 Some teachers were appointed as float teachers: each was to be on the staff of both a secondary and a primary school to institute curricular continuity between the schools and to be a link person for pupils experiencing problems in the primary school. Most float teachers worked whole days in each school to minimize the amount of travel and to increase their informal contacts with other members of staff.

4.20 Bill Fordyce used two main methods to oversee the progress of the policies:

> I can drop into a school and into a classroom or teaching area but that only gives me a very small random sample of what is going on. My colleagues and I also meet the area teams regularly. I've attended 51 such meetings in the last 12 months to find out their concerns and worries.

4.21 They established two working groups to generalize the work going on in individual area teams. One collected and collated useful 'home-made' materials which (at the time I wrote this) were being made into reference books for the use of remedial and classroom teachers and subject specialists. The other group reviewed published materials and produced reports for circulation within the authority.

4.22 In order to increase the numbers of trained remedial teachers they built up their relationship with a local college which put on additional courses. However, Bill Fordyce was wary of existing training schemes:

> The existing qualification for remedial teachers is not satisfactory from our point of view—it relies too much on the idea that remedial provision looks at basic problems only in English and maths. It doesn't look at issues right across the curriculum or at co-operative teaching. That's why we've been a keen supporter of the proposed new diploma in learning difficulties.

4.23 According to Bill Fordyce, they met surprising little resistance to their proposals. Some teachers had changed little in the last 20–30 years and still regarded educational theory as consisting of 'a blackboard, a piece of chalk and a text book'. A few remedial teachers were apprehensive about moving out of the remedial class or stopping a practice of seeing 'one youngster at a time for twenty minutes':

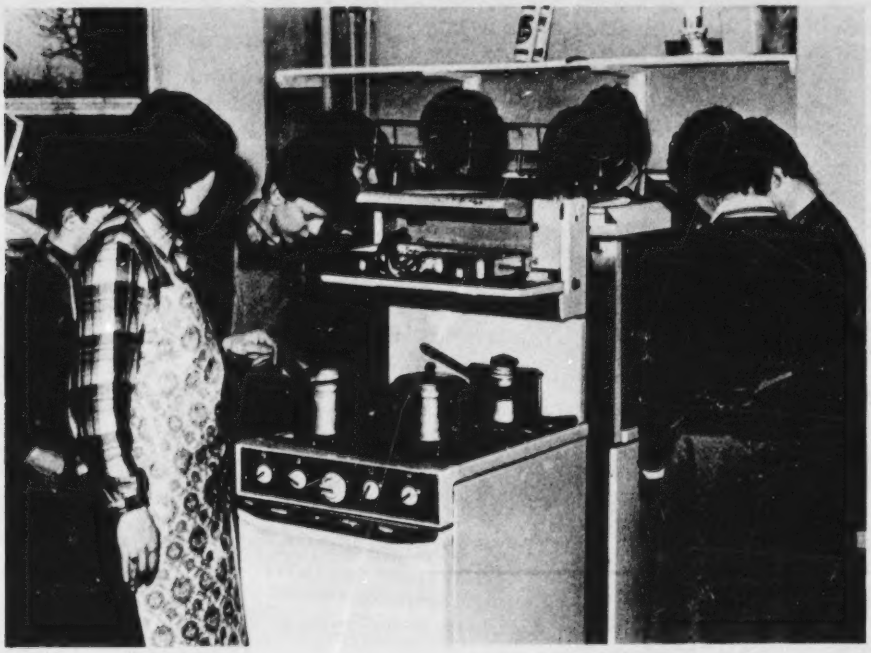
> We carried out a survey of opinions of head teachers, remedial teachers, class teachers and subject teachers to find out what they felt about the provision. It would be unfair and foolish of me to say that all the remarks were complimentary. We do get clashes at times between a remedial teacher and a class teacher or a remedial teacher and a subject teacher. We have to find out how to minimize the problems which arise when people work together. But on the whole they felt it was better than what was provided before and I must be satisfied.

4.24 Before the scheme started he had anticipated greater problems in making changes in the secondary schools than the primaries, but they found the reverse to be true:

> On the whole the idea of co-operative work between a remedial teacher and a class teacher has been much more easily implemented in secondary schools than primary. Now you've asked me why, I wish I could answer, but I really don't know.

Too many cooks?

4.25 Christine Crispin, the principal remedial teacher from Powis Academy (a comprehensive school) has a team of three full-time and three float teachers who alternate their days between that school, where they are attached to the first year, and the primary schools. The first year is totally mixed ability; all children do modern languages (French in the first year), and a new French scheme designed for all ability levels has been piloted in the school. She regards the Grampian working party report as her 'bible': 'They said go forth and interpret, girls.' She has attempted to change working methods gradually and is careful that her remedial teachers should not seem to be too critical of existing methods when they advocate a different approach. The remedial teachers made it a rule that the work of subject colleagues was not to be discussed in the staffroom: 'the rules of the confessional apply'.



Co-operative teaching in Grampian between subject and remedial specialists: cookery and French.

4.26 She described the work that she had been doing with the home economics classes in a newsletter produced by Aberdeen College of Education. After hearing a talk given by Margaret Taylor, the principal regional psychologist, the principal home economics teacher at Powis decided that the remedial department might have something to offer her. Christine Crispin described the co-operative work that emerged:

> Kitchens are larger than normal classrooms, and copying from the blackboard is more difficult: not only is the blackboard often a long way away, but also it is often difficult for all the children to sit facing it conveniently. One of the first tasks was to produce clearly lettered recipe cards for the entire S1–S2 syllabus. (These were covered with plastic film.) Each pupil now has an individual card to work from, and the difference in the pupils' books is dramatic: recipes look like recipes; spelling and copying mistakes are minimal; and the *time* needed for copying is significantly reduced. Experience in the HE (home economics) classroom has convinced me that time is almost always at a premium . . . During a cookery lesson, there is simply no time to give instructions one-by-one, or to go on repeating them for the benefit of individual pupils. A second teacher in the room can help slower children to carry out instructions without affecting the pace of the lesson for others who *are* able to manage. As the former PT [principal teacher] had remarked, it was enjoyable moving about the kitchen supervising practical work *without* a 'living tail' at her back, hands and voices raised in question. (Can a 'tail' have either?)
>
> With another teacher in the room, there is no embarrassment about asking questions when instructions have not been understood: a question which reveals lack of comprehension or poor memory will no longer have to be paraded before the whole class, and will not delay work for the whole class. It has come as something of a surprise, in these early days, to find that the least able in the HE class are not always the least able in other, more academic areas of the curriculum. Children with already recognized weaknesses in literacy and numeracy, of course, need much support, but they are by no means the only children who can benefit from extra attention.
>
> (Crispin, 1981, pp. 3–4)

4.27 Christine Crispin has had particular involvement with a CSE boys' class. Seven of its fourteen pupils had already been known to the remedial class because of their literacy and numeracy problems. One of the other boys was partially sighted:

> We agreed that I should work with this class for three periods out of their five-period allocation to the CSE course—two periods of practical work and one of theory. We saw the partially sighted boy as my prime concern, but, although I spend a great deal of time by his side—copying his recipes, getting out his equipment, handling hot dishes, etc., a close involvement has developed with the *whole* class. That I have been accepted as part of a 'teaching team' for the class is due, I am sure, to the attitude of the HE teacher: I am not looked on as an outsider, but as a welcome and integral part of the provision for that class. I had to miss several classes recently, and the boys afterwards were anxious to tell me that the partially sighted boy was having an 'affa job' without me, making it necessary for the HE teacher to slow down the pace of the lesson.
>
> Each lesson is planned by the HE teacher, and we discuss the teaching aids that she would like me to make. We have begun to prepare recipe cards, posters and worksheets for particular topics. Next term we are getting ready to tackle the problems of accurate weighing and measuring. To save time, already weighed ingredients are usually provided for the practical lessons, but some of the boys want to try out their new skills at home and we must teach them to use scales.
>
> (Crispin, 1981, p. 5).

Double science

4.28 Television programme 7 contains a sequence in which a science specialist and the principal remedial teacher at Northfield Academy teach together on a science foundation course. For the third and fourth year of the Scottish secondary school, the Munn Report had recommended three types of course for which students would be banded by ability, attainment and interest: foundation, general, and credit courses (Scottish Education Department, 1977b). Now, clearly, this re-introduces an element of separation for slow learners and I will return to this later. The team teaching has been built up gradually and I have edited and re-ordered an account given by Ian, the science specialist, and Joan,

the remedial teacher, about the way such teaching was introduced into school and what they feel about its usefulness in science lessons:

Joan It wasn't easy to implement the new remedial policy. This is a traditional school. There had been no co-operative teaching. I started by going round to all the heads of department and discussing the possibilities of working together. We offered to put remedial teachers into the classrooms of those who were interested in the new system. It would have been pointless to force remedial teachers into the classrooms with class teachers. There'd be no benefit to pupils or teachers in that kind of atmosphere. We made it clear that it wasn't the remedial teacher's job to take over. We started gradually and we've gone from strength to strength. Of course we've had our failures. It hasn't worked well in every case and some people were just not willing to open the door at all . . . But we're trying to show by example that where it's working it's working well and we hope this success will rub off on other departments.

Ian It wasn't a case of having anyone thrust upon me. I invited Joan's co-operation. We were developing a new science syllabus to make the work more meaningful for children of lower abilities. With the enhanced remedial provision in Grampian it would have been foolish for me to ignore this opportunity.

Joan We are trying to move away from the traditional form of teaching; of feeding the pupils information and then asking them to regurgitate it. We are trying to encourage the pupils to think for themselves. This is the strength of co-operative teaching. We plan the lesson together and toss around ideas, backwards and forwards, and think up different ways of presenting the material so that we can get these pupils to think things out for themselves.

Ian After the lesson we are able to analyse what has gone on. Before, with a teacher working by himself, we did not have the inclination to sit down and analyse the teaching process.

Joan We discuss what has worked well and what was a waste of time and we know each other well enough to say, 'That didn't work well, let's scrap that and look at a different way of approaching it.' We don't feel threatened if we criticize each other and this is a strength of our work.

Ian I wouldn't expect a remedial teacher to tell me about the scientific content. But they can tell me whether they think it is appropriate and at the right level and comment on method. It's easy for a teacher to get carried away with the importance of their own subject.

Joan We really share the class teaching; we are shoulder to shoulder as class teachers. This is the second year we've worked with this class. Initially I was very wary but now it's so relaxed that I can intervene at any point. If I feel they haven't understood something I pick it up and put it across in a different way.

Ian They see us both having our responsibilities; we take equal responsibility for lesson planning, discipline and for the work of the pupils.

Joan The individual pupil gets extra attention from the teacher. We have time to go round, each in our own way, and spend at least five minutes if necessary with the pupil in a one-to-one situation explaining any difficulties they have . . . The pupils are more willing to ask when there's two of us in the room, they don't feel they are dragging the teacher away from the main class.

Ian It also means that if one of us is away there is still teaching continuity. The pupils are able to relate to us equally. If they become bored or distracted they tend to slip into disruptive behaviour. But with both of us in the room we can deal with their needs there and then.

Joan One girl had remedial help throughout primary school and again in secondary school: extra work in basic reading and number. Without the co-operative teaching I feel that she would have just opted out. Her attendance has actually improved.

Ian I can think of one boy who constantly seeks attention. In a normal classroom he would have been a pest; refusing to do anything. The teacher would have either had to discipline him in some way or exclude him from the class just to allow the work to continue for the rest of the class. With both of us there we can sit down with him and encourage him.

The general response

4.29 As you might expect, not all teachers have reacted as positively as Ian and Joan. The equal relationship which they have achieved takes time and commitment. In their survey of remedial work in Grampian, Neil Ferguson and Muriel Adams (1982) found that pre-planning and discussion after lessons did not always take place. They found that 'only five of the 41 remedial teachers jointly prepared and taught lessons with a subject specialist'. Many were cast in the role of helper—aiding children in the class who were having difficulties with the lesson or worksheets introduced by the subject teacher. We have to beware of interpreting the results of surveys which rely on questionnaires and are not based on direct observation and interpretation of the practices they describe, but the comments from subject teachers did reveal a certain amount of unease:

> One class teacher described remedial teachers as 'rather ingratiating—embarrassed by their position. They have an urge to justify their existence.' Another commented testily 'she (the remedial teacher) is inclined to want to take over the whole class. Suddenly she's in the middle directing the class if I got out for a minute.'
>
> (Ferguson and Adams, 1982, p. 27).

4.30 John Henley, the principal teacher for Deans Community School in Livingstone, has attempted to summarize for me the national response from remedial teachers, and I have included his view of their reactions as Appendix 2.

A new training

4.31 The Scottish colleges of education took up the proposal of the Scottish Education Department and established a committee in June 1980 to decide the form to be taken by a new one-year diploma in learning difficulties in primary or secondary education. Their proposals were accepted in January 1981. The aim of the course was to enable remedial specialists to discharge four roles:

(a) to act as a consultant for other members of staff;

(b) to provide personal tuition and support for children with severe difficulties;

(c) to provide supportive help in the classroom in co-operation with class and subject teachers;

(d) to provide special services for children with temporary learning or emotional difficulties.

The major new element in the training was seen to be the consultancy role. 'It was the hallmark of the new diploma and the most important strand' (Joint Committee of Colleges of Education in Scotland, 1981). The course was to be 'strongly practical' with 'a substantial contribution by practising teachers and administrators in the planning and teaching of the course'. The report provides a checklist of skills and knowledge in relation to the four roles. The skills expected in the consultancy roles were as follows:

(a) *Curricular* to be able to:

- help with the design and evaluation of courses;
- help to effect a match between the demands of school work and the characteristics and competencies of learners by advising on differentiation within the curriculum;
- assess the level of difficulty of materials used across a range of subjects in terms of concepts, relevance, readability and presentation.

(b) *Methodological* to be able to:

- advise colleagues on aspects of methodology which contribute to learning difficulties;
- advise colleagues about resources and resource services appropriate to pupils with learning difficulties;
- advise colleagues about the range of learning difficulties in individual pupils;
- help colleagues to devise teaching and learning strategies.

(c) *Managerial* to be able to:

- engage with individuals or groups in the process of review and development within schools;
- contribute to the analysis of situations in schools or departments in schools;
- contribute to the planning and implementation of changes, both curricular and organizational;
- liaise with colleagues, with parents or with outside agencies;
- act as an advocate on behalf of pupils with learning difficulties.

(Joint Committee of Colleges of Education in Scotland, 1981)

4.32 A list of contents of the course developed at Moray House College of Education is included as Appendix 3. Marion Blythman, the head of the Special Education Department there, has stressed the emphasis in the new course on the relationship between theory and practice:

> Forty per cent of the course hours are spent in schools. The examination and analysis of school situations and pupils' work provides the raw material for a close scrutiny of the learning difficulties experienced by pupils. The practical school-based work is planned to relate precisely to the college-based studies. Together these will provide a background of experience and a theoretical perspective which will equip the course members to give pupils with learning difficulties greater access to the curriculum.
>
> (Blythman, personal communication)

A credibility gap?

4.33 Some people are concerned that the new diploma will be seen as the beginning and end of training to implement the new policies:

> Let us take for granted that a structure of national and local in-service training is needed . . . And let us accept that teachers should return from courses refreshed, equipped with new ideas, reinforced in existing practices and enthusiastic about trying things out. But let us not assume that courses are any more than enabling devices offering the 'student' information, ideas, knowledge, techniques and an invaluable forum for discussion. The moment of true professional development of the individual and of true development of curriculum and curriculum practices occurs only in the process of teaching.
>
> (Lamont, 1981, p. 6)

The development of policy can only take place within the schools of a particular region and the initiatives have to be continually and subtly fostered:

> It is certainly possible to enforce organizational changes which may well imply changes in method and technique, and, like the threat of execution, an inescapable change in organization can concentrate the mind wonderfully. Yet there is no certainty in the effectiveness of enforced reorganization as a means of initiating development: the experience of mixed ability organization is a case in point, where the implications for group teaching, individualized learning, profile assessment and so on can be blatantly ignored and class teaching to the middle of the ability range continue as the sole teaching technique. In remedial education, co-operative teaching is in a similar situation: given the will to make it work it seems very successful, but if enforced it can simply lead to unwilling teachers sitting in someone else's classroom doing very little constructive work.
>
> (Lamont, 1981, p. 7)

4.34 It is a strength of the present policy developments that the implications for teaching as well as for organization are kept to the fore. In themselves they provide a form and forum for in-service training and curriculum development in schools which seem very attractive to me and which could serve as a model for in-service initiatives elsewhere, particularly if there is also an emphasis on sharing and spreading good practice.

4.35 All professional training carries the danger that the expertise will be seen to reside in the qualification rather than the person who has it. Often the training may create a set of expectations both in the trainee and in others awaiting her skills that simply cannot be fulfilled. All 'professionals' should be willing to have their personal qualities assessed

before they can expect their clients or colleagues to trust their skills and judgement. This is most difficult for those whose expertise is necessarily or deliberately hidden. In co-operative teaching, such subterfuge is impossible and it is this possible removal of the credibility gap between the promises and practices of remedial specialists which makes their new role challenging and interesting. As Margaret Taylor, the principal regional psychologist in Grampian, remarked:

> Remedial teachers will learn far more about a young person's learning difficulties within a classroom and from discussion with class or subject teacher than from any test yet devised. The class or subject teacher will learn more about how to utilize the help of the remedial teacher by working together and talking together than from any test score, or report, or message from the remedial staff.
> (Taylor, 1981, p. 7)

The nature of the reforms

4.36 The Scottish approach to pupils with learning difficulties represents an unprecedented attempt to break the cycle in which classroom inflexibility provokes withdrawal and separation of some pupils (see Figure 4, p. 40). It is no more than would be suggested within many individual schools outside Scotland. One of my E241 students in the south east of England criticized current remedial provision in terms which precisely echo those of his Scottish colleagues:

> Unfortunately many schools still cling to the traditional role of the remedial department being like an ambulance service—a service operating in a vacuum independent of the rest of the school and very often independent of its curriculum.

4.37 But although it is possible to point to isolated examples where remedial education is given a broader and more powerful role in schools, I know of no examples outside Scotland where one local authority has co-ordinated individual efforts into a regional policy and certainly there is an absence of national guidelines. In such circumstances, those wishing to innovate have to expend much of their energy on getting schemes off the ground and preserving them from competing priorities.

4.38 My student's point was made in the context of an attempt to understand why ordinary schools need to request transfer of pupils to ESN(M) schools or schools for children with moderate learning difficulties. After all, the same adaptations needed to increase the participation of those children already in the school might also facilitate the inclusion of a wider group of children. Bill Fordyce did recognize this possibility in Grampian:

> One of the interesting things that has happened where we have had our new remedial scheme going for nearly four years now is that primary and secondary schools are saying we don't think this youngster needs to go to the special school because we've got the kind of support facilities that we require.

4.39 But the connection between organizational and curricular reform in comprehensive education and integration was not recognized in the official documents issued by the Scottish Education Department. In fact in 1981 the Scottish inspectorate issued a report on 'mildly mentally handicapped' pupils of secondary school age in which, although they were critical of much of the curriculum within the special school, they clearly saw the special school as the appropriate place for the education of these children (Scottish Education Department, 1981).

4.40 There was a divergence, too, between the message of the Pack Report, which leant impetus to the establishment of separate units for disaffected pupils, and the schools' responsibility for disaffection implied by the inspectors' 1978 report. In Unit 13 (section 4), I linked responses to both failure and disaffection to critiques of schooling. Neil Toppin, head of St Augustine's School in Glasgow, made the connection quite clear in Television programme 7. He argued:

> There are those who believe that we ought to establish disruptive units. There are others, myself included, who reject the whole philosophy behind 'sinbins', as they have been called, and believe that there's a better way of dealing with children . . . For too long children have been forced to adjust to the institution,

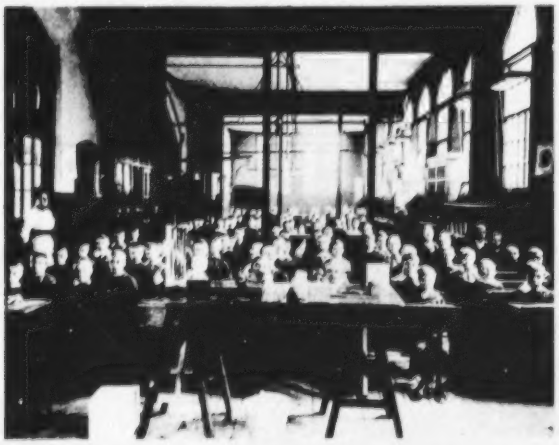
and the institution has never adjusted to the child. The philosophy followed in this school is that the institution as far as is humanly possible will be made to adjust to the needs of a disaffected or disruptive child.

4.41 Nor did the inspectors' 1978 report make a link between a critique of current provision within comprehensive schools and a need for greater participation by the community. There have been a number of interesting developments in community education in Scotland but the Lothian report on provision for the least able pupils in secondary schools stands out in the priority it gave to parent involvement:

> Many teachers perceive the parents of the least able pupils as uninterested in the education of their offspring because they do not respond well to invitations to come to the school. This perception is mistaken. The reality is that many parents who regard themselves as less articulate than they feel is necessary are apprehensive of schools and of teachers. Many who have made the effort to attend meetings have then had the experiences of being 'flannelled', thus confirming their apprehension and their perception of themselves as inadequately equipped to ask their questions and express their aspirations in terms which will get through to the experts.
>
> For active engagement of parents in curricular decisions, teachers must perceive the parents of the least able pupils as people with as much experience of life as the teachers have, as people who on the whole know their children, as people who are deeply interested in their children's education and who need clearly presented information to give practical expression to that interest.
>
> (Lothian Regional Council, 1980, p. 30)

You will be aware that this still falls a long way short of community participation.

The limits to change: classrooms then as now.



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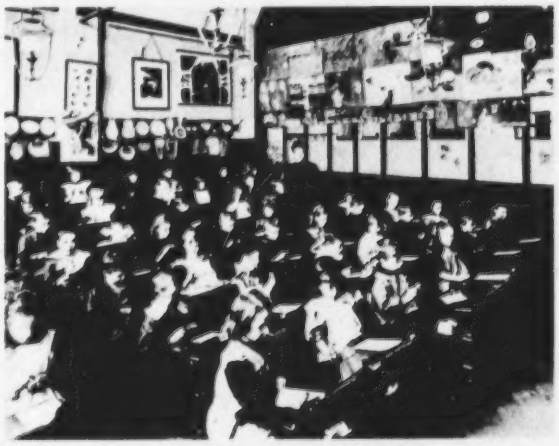

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4.42 I suggested that the policy initiatives can be seen as an attempt to reform comprehensive schools by seeing them through the eyes of pupils with learning difficulties. But this approach has led to some anomalous terminology. Although 50 per cent of pupils may be provided with a deficient curriculum, should these pupils be regarded as having learning difficulties? The assumptions in the reports are quite clear that it is not 50 per cent of the pupils who need a remedy but the curricula of the schools, and the implication is that the number of ailing curricula is closer to 100 per cent. Shouldn't this shift of emphasis be reflected in the words that are used? Shouldn't the remedial specialist be thought of as a support teacher for mixed ability and team teaching? Shouldn't the learning difficulties diploma be self-consciously about the development of a comprehensive education for all?

4.43 But not all the trends within Scottish education are towards a unified comprehensive system. A foundation science class which descended from the recommendations of the Munn Report was described earlier (para. 4.28). That report, as you may recall, recommended three distinct syllabuses for the third and fourth year of secondary schooling, and, as Malcolm Bain remarked:

> Perhaps a generation of educationists as yet unborn will look at the three syllabuses and the three levels of learning certificate and conclude that what we require is, in fact, three types of school to cater for the needs of the three groups of pupils: and thus the magic roundabout will spin again.
>
> (Bain, 1979, p. 89)

4.44 Ultimately, the progress of the reforms depend on how much real change can be made in the organization and curricula of the schools. The aim of co-operative teaching and curriculum development within the schools is to make classrooms more flexible, yet the large class group with its teacher or teachers has remained the central organizing principle of schools since their inception.

4.45 To what extent are schools bound by their history and to what extent is this history determined? In the final section of this unit I will explore the limits to change.

5 *What has to change?*

5.1 This unit has asked a simple question: if handicaps are to be prevented what has to happen? But the answer we can give is simple only when a handicap can be avoided by an inexpensive straightforward intervention directed at individual children or adults. Some cases of genetic counselling or the screening for and treatment of phenylketonurea may fall into that category, but, in the vast majority of cases, prevention involves difficult and complex moral, political and economic choices. Handicaps are social creations and their prevention must depend on some form of social change. At different points in this unit, the apparent target for prevention has been individual children and parents (usually mothers), schools, local educational authorities or even the political and economic order. Each section of this unit has tried to make clear that most areas of prevention must involve changes at all levels of the system from the individual to political structure. This is an inevitable consequence both of the way individual lives are constructed within social and cultural constraints and of the social and cultural repercussions of personal action. But people differ in the extent to which they believe prevention depends on fundamental social and political reorganization. In one of his Reith Lectures, Ian Kennedy criticized medical practice for ignoring the social determinants of ill health:

> With the decline of serious threats to health from infections, our health care system has turned away from environmental considerations towards the notion of personal health care. It has become an illness service rather than a health service . . .
>
> (Kennedy, 1980)

And in doing that medical practice failed to take account of the continuing and widening gap between the health of social groups:

> It is no rhetorical device to describe the disparities in the present provision of health care among the various groups in our society as a scandal . . .
>
> At birth and in the first month of life, the death rate of babies born to parents in social class five, the unskilled, is double that of babies born to parents in social class one, professional workers. In the next eleven months four times as many boys and five times as many girls in class five die as in class one . . .
>
> The 1979 report of the Royal Commission on the National Health Service noted weakly that in terms of health, 'the position of those in social classes four and five appears to have worsened relative to those in social classes one and two since the inception of the National Health Service in 1948'.
>
> (Kennedy, 1980, p. 678)

5.2 Ian Kennedy argued that 'the obstacles in the way of reshaping and improving our health care . . . are the product of political and economic decisions and circumstances. So, if there is to be any improvement, it will only come through major political, social and economic changes' (Kennedy, 1980, p. 676).

5.3 In analysing the criticisms made by young people in a study of the youth service conducted at Keele, Eggleston concluded that while the young people's needs could be better served, this would not require radical change:

> Most of the young, including the deviants, wished to count for something, or at least have the chance to do so, in a society similar to the present one, not a radically different one. The call was for a wider distribution of power rather than for a new distribution. Certainly it is arguable that in the power structure of most industrial societies redistribution is not only possible but desirable and it may be achieved without fundamental change.
>
> (Eggleston, 1980, p. 39)

But would a society in which everyone 'counted for something' be much the same as the present one?

The possibility of reform

5.4 In *Good as Gold*, Joseph Heller's hero is a professor of English who achieves his cherished ambition of becoming a White House adviser because the president is interested in his neat turn of phrase (Heller, 1979). One of his phrases is 'Every change is for the worse'. It has become customary for opponents of capitalism to display the sinister motives behind 'progressive' reform which link it to alien political and economic interests. Thus Andrew Scull described the decarceration of people from institutions into the cities of America as a cost-saving exercise under the guise of reform (Scull, 1976). We have thought of people in institutions as shut away. But increasing media attention and public revulsion places such institutions in the public eye. In such circumstances the handicapped can be made *less* visible by dispersing them among the nuclear families which are called the community. Jackie Lukes argued in her Reader article that the 1981 Act and government support of integration was a plot to achieve a similar purpose (Reading 5.2). This provoked a vigorous denial from an administrator in the DES and is hardly supported by statistical trends anyway. In attempting to account for discrepancies between rhetoric and practice I saw the assertion that integration was happening as a neat way of promoting the opposite process. If it is happening then we do not need to promote it. If we don't promote it then the forces for segregation can continue.

5.5 In looking at changes in educational policy it is as well, then, to be suspicious. As Shapiro (1980) suggested:

> While we do not dismiss the importance of educational pressure groups and innovators as catalysts for change, our belief is that the extent of the change depends, in the final analysis, not on the perseverance and commitment of these individuals or groups, but on the parameters set by the social and economic structure. Special education reform, like other areas of educational change, may proceed only to the extent that it is congruent with the needs or goals of that structure.
>
> (Shapiro, 1980, p. 212)

And because the prevailing economic forces may run counter to the interests of disadvantaged groups one has to look closely at any apparent reform. One has to ask not only, 'Who benefits?', but, 'Who loses?'. In a situation of limited employment, for example, the achievement of employment opportunities by one disadvantaged group is generally at the expense of another such group. In the US, Richard Weatherley documented the way funds made available for the handicapped in Massachusetts were absorbed to a disproportionate extent by rich districts who had the initial resources to complete the paperwork enabling them to obtain further funds (Weatherley, 1979).

5.6 It might be tempting to argue from the absence of movement towards integration in the UK that segregation itself was so intimately connected to processes of economic and political reproduction that no change was possible. This is a line taken, apparently, by Sally Tomlinson in her study of children categorized as ESN(M) (Tomlinson, 1981). She sees the presence of a form of education designed to withhold credentials from its students as a means for keeping mainstream students in line. Such a view is evident too in the case study of the relationship between a school for mentally handicapped students and the labour market (Case study 30). The existence of a group of students who are 'legitimately' unemployed reinforces the legitimacy of the connections between the distribution of jobs and abilities displayed in school.

5.7 Now such examples seem to depict society, if not as the hurtling train of Unit 13, then at least as a 'tight ship'. Yet clearly change does occur: some developed countries and some LEAs, for example, have made strides towards an integrated education system. Innovations in education such as those taking place in Grampian do occur without any massive political upheavals.

5.8 But does the economic and political system constrain institutional change? In exploring possibilities for reform, one can ask more questions: 'How far can it go?' 'How widespread can it become?' These are questions about the depth and breadth of change. It is one thing for localized reform to occur and quite another for reform to spread throughout the system. Yossarian in Joseph Heller's *Catch-22* is kept in line when he refuses to fly any more bombing missions with the phrase 'Suppose everyone felt that way,' to which he replied, 'Then I'd certainly be a damned fool to feel any other way, wouldn't I?' (Heller, 1962; p. 470 of the paperback edition). But while the efforts of the American airforce would only be marginally affected by losing one operational airman its activities would be completely curtailed if all the airforce refused to fly simultaneously. Similarly, democratic education at Countesthorpe school in Leicestershire does not threaten the authoritarian order of our institutions simply because it is one of a very few such examples. And in fact the permissiveness in the system which allows a certain amount of reform to take place may actually divert, localize and contain any pressure to alter the system as a whole.

5.9 But there is a further constraint on reform. For the possibility of widespread reform is curtailed, not simply because it would be stopped if it spread too far, but because as things are it would not be initiated. By and large those in power want things to remain as they are. That's why major reforms involve a change in those in positions of power. In section 2, I noted how some people can try to overcome the conditions which create disparities in health services between social classes. But there would have to be a radical change in the class basis of society before everyone thought in that way. And if everyone thought in that way the disparity of services would have disappeared.

Is an end to discrimination in sight?

5.10 Chris Davis, who has athetosis, an inability to control voluntary movements, made a film for the BBC2 *Open Door* programme entitled *Attitudes the Second Handicap*. He argued that it was the attitudes of people towards disability which unnecessarily exacerbated the problems associated with a physical impairment. During the course of the programme Kevin Mulhern, a contributor to *Does He Take Sugar*, suggested that handicapped people along with other oppressed groups needed the protection of a single piece of anti-discrimination legislation. Such a law might have the obvious consequences, such as making it an offence to fail to make access for the handicapped to buildings, but it might also affect the legality of current medical practices of abortion and euthanasia of handicapped babies. But as we have seen with the anti-discrimination laws now in force, they seem to affect only the grossest public breaches of the law, and there are clearly some

groups, such as the creators and enforcers of immigration policy, who are not subject to its constraints. Discrimination against handicapped people is a consequence of a system of values which rewards and applauds people for their talents and physique. It is revealed by the fears of mothers that they may give birth to a handicapped baby and by parental aspirations for their children. It is enshrined in an education system which progressively excludes children on the grounds of their ability.

5.11 Now I am not suggesting that no changes in attitude can occur. And I believe that integration within education is a powerful and essential means for accomplishing such changes. But these changes can only be limited while the system of values which breeds discrimination against imperfections of mind or body remains in force.

The progress of integration

5.12 Would the general adoption of a policy of integration involve a widespread change in the distribution of power within the system? The answer is complex. I argued in Unit 10 that widespread reform involved the introduction of a centrally directed policy. And with such direction it is clearly possible to see virtually all handicapped children in ordinary schools and a greater relevance of the curriculum for a much wider group of children. But the extent to which 'the participation of children in the social and educational life of comprehensive schools' can proceed is ultimately limited by the degree to which power can be handed over to pupils and their communities. The point of maximum participation for handicapped students is determined not only by their capacities but by the willingness of schools to *permit* their participation. In attempting to make the curriculum relevant to the needs of greater numbers of pupils it could be argued that the Scottish policy makers were going some way down the road towards community education. But they certainly stopped a long way short of a general plan to involve communities in determining the curricula of their schools.

The poverty of opportunity

5.13 In examining educational reforms you can ask a further set of questions: 'What is revealed by it?'; 'What is obscured by it?'. We can distinguish between conservative reforms, which decrease the likelihood of fundamental change by obscuring problems, and radical reforms, which help to expose the system's contradictions. All attempts at prevention which attempt to relieve the burden of a single individual while doing nothing to alter the social conditions which give rise to handicaps are conservative in this way. Many prevention schemes have been openly related to a philosophy of equality of opportunity, the ideology which is the major force in obscuring disparities of power and material resources between social groups. Compensatory education schemes, home visiting schemes, community involvement projects, can all be viewed in this way, and Jean Barr's case study beautifully illustrated the divergence in views about the needs of the Glasgow women as identified by the initiators of the project and by themselves. How could such a community scheme equalize the opportunities of their children? But it is not sufficient to display the inconsistencies of a philosophy of equal opportunity on one occasion for us to move beyond its effects. For ideology encloses us like a self-sealing bubble. The sharp point of rationality which we may finally hope will prick and explode it merely leaves a minute and temporary hole. In re-tackling this issue I have called on the diverse reinforcements of R. H. Tawney and Kurt Vonnegut. Tawney calls the view that society should be run according to the provision of equal opportunities the Tadpole Philosophy:

> It is possible that intelligent tadpoles reconcile themselves to the inconveniences of their position, by reflecting that, though most of them will live and die as tadpoles and nothing more, the more fortunate of the species will one day shed their tails, distend their mouths and stomachs, hop nimbly on to dry land, and croak addresses to their former friends on the virtues by means of which tadpoles of character and capacity can rise to be frogs. This conception of society may be described, perhaps, as the Tadpole Philosophy, since the consolation which it offers for social evils consists in the statement that exceptional individuals can succeed in evading them. Who has not heard it suggested that the presence of opportunities, by means of which individuals can ascend and get on, relieves

economic contrasts of their social poison and their personal sting? Who has not encountered the argument that there is an educational 'ladder' up which talent can climb, and that its existence makes the scamped quality of our primary education—the overcrowded classes, and mean surroundings, and absence of amenities—a matter of secondary importance? And what a view of human life such an attitude implies! As though opportunities for talent to rise could be equalized in a society where the circumstances surrounding it from birth are themselves unequal! As though, if they could, it were natural and proper that the position of the mass of mankind should permanently be such that they can attain civilization only by escaping from it! As though the noblest use of exceptional powers were to scramble to shore, undeterred by the thought of drowning companions!

It is true, of course, that a community must draw on a stream of fresh talent, in order to avoid stagnation, and that, unless individuals of ability can turn their powers to account, they are embittered by a sense of defeat and frustration. The existence of opportunities to move from point to point on an economic scale, and to mount from humble origins to success and affluence, is a condition, therefore, both of social well-being and of individual happiness, and impediments which deny them to some, while lavishing them on others, are injurious to both. But opportunities to 'rise' are not a substitute for a large measure of practical equality, nor do they make immaterial the existence of sharp disparities of income and social condition. On the contrary, it is only the presence of a high degree of practical equality which can diffuse and generalize opportunities to rise. The existence of such opportunities in fact, and not merely in form, depends, not only upon an open road, but upon an equal start.

(Tawney, 1931, pp. 108–9)

Tawney concentrates on the contradiction of advocating 'equal opportunities' when people have unequal starting positions. In *Jailbird*, Kurt Vonnegut uses a fable to point up the strict structural limits placed on the numbers of people who can take up the opportunites defined and offered by society.

And then I regaled myself with a story by my prison friend Dr Robert Fender, which he had published under the name of 'Kilgore Trout'. It was called 'Asleep at the Switch'. It was about a huge reception centre outside the Pearly Gates of heaven—filled with computers and staffed by people who had been certified public accountants or investment counsellors or business managers back on Earth.

You could not get into heaven until you had submitted to a full review of how well you handled the business opportunities God, through His angels, had offered to you on Earth.

All day long and in every cubicle you could hear the experts saying with utmost weariness to people who had missed this opportunity and then that one: 'And there you were, asleep at the switch again.'

How much time had I spent in solitary by then? I will make a guess: five minutes.

'Asleep at the Switch' was quite a sacrilegious story. The hero was the ghost of Albert Einstein. He himself was so little interested in wealth that he scarcely heard what his auditor had to say to him. It was some sort of balderdash about how he could have become a billionaire, if only he had gotten a second mortgage on his house in Berne, Switzerland, in nineteen-hundred and five, and invested the money in known uranium deposits before telling the world that $E=Mc^2$.

'But there you were—asleep at the switch again,' said the auditor.

'Yes,' said Einstein politely, 'it does seem rather typical.'

'So you see,' said the auditor, 'life really was quite fair. You did have a remarkable number of opportunities, whether you took them or not.'

'Yes, I see that now,' said Einstein.

'Would you mind saying that in so many words?' said the auditor.

'Saying what?' said Einstein.

'That life was fair.'

'Life was fair,' said Einstein.

'If you don't really mean it,' said the auditor, 'I have many more examples to show you. For instance, just forgetting atomic energy: If you had simply taken the money you put into a savings bank when you were at the Institute for Advanced Studies at Princeton, and you had put it, starting in nineteen-hundred and fifty, say, into IBM and Polaroid and Xerox—even though you had only five more years to live—'

The auditor raised his eyes suggestively, inviting Einstein to show how smart he could be.

'I would have been rich?' said Einstein.

' "Comfortable," shall we say?' said the auditor smugly. 'But there you were again—' And again his eyebrows went up.

'Asleep at the switch?' asked Einstein hopefully.

The auditor stood and extended his hand, which Einstein accepted unenthusiastically. 'So you see, Dr Einstein,' he said, 'we can't blame God for everything, now can we?' He handed Einstein his pass through the Pearly Gates. 'Good to have you aboard,' he said.

So into heaven Einstein went, carrying his beloved fiddle. He thought no more about the audit. He was a veteran of countless border crossings by then. There had always been senseless questions to answer, empty promises to make, meaningless documents to sign.

But once inside heaven Einstein encountered ghost after ghost who was sick about what his or her audit had shown. One husband and wife team, which had committed suicide after losing everything in a chicken farm in New Hampshire, had been told that they had been living the whole time over the largest deposit of nickel in the world.

A fourteen-year-old Harlem child who had been killed in a gang fight was told about a twenty-two-carat diamond ring that lay for weeks at the bottom of a catch basin he passed every day. It was flawless and had not been reported as stolen. If he had sold it for only a tenth of its value, four hundred dollars, say, according to his auditor, and speculated in commodities futures, especially in cocoa at that time, he could have moved his mother and sisters and himself into a Park Avenue condominium and sent himself to Andover and then to Harvard after that.

There was Harvard again.

All the auditing stories that Einstein heard were told by Americans. He had chosen to settle in the American part of heaven. Understandably, he had mixed feelings about Europeans, since he was a Jew. But it wasn't only Americans who were being audited. Pakistanis and pygmies from the Philippines and even communists had to go through the very same thing.

It was in character for Einstein to be offended first by the mathematics of the system the auditors wanted everybody to be so grateful for. He calculated that if every person on Earth took full advantage of every opportunity, became a millionaire and then a billionaire and so on, the paper wealth on that one little planet would exceed the worth of all the minerals in the universe in a matter of three months or so. Also: There would be nobody left to do any useful work.

So he sent God a note. It assumed that God had no idea what sorts of rubbish His auditors were talking. It accused the auditors rather than God of cruelly deceiving new arrivals about the opportunities they had had on Earth. He tried to guess the auditors' motives. He wondered if they might not be sadists.

The story ended abruptly. Einstein did not get to see God. But God sent out an archangel who was boiling mad. He told Einstein that if he continued to destroy ghosts' respect for the audits, he was going to take Einstein's fiddle away from him for all eternity. So Einstein never discussed the audits with anybody ever again. His fiddle meant more to him than anything.

(Vonnegut, 1979, pp. 188–91).

5.14 If we are to prevent the unfair burdens which can create and constitute handicaps in children, then not only may we have to reduce inequalities in material circumstance but allow people with different abilities and interests to define their goals for themselves.

But what should we do tomorrow?

5.15 What we can do tomorrow depends on who we are and what we want to do and even on what we are paid to do. The extent to which we can prevent handicap is constrained but that does not mean that nothing can be done. And we should not allow pressures to do something to force us to propound and support prevention fantasies which make it less likely that children's lives can be changed for the better. Units 10 and 13 ended with a single lesson. Positive change comes about through concerted effort; through the creation and maintenance of policy. That is a message that is continued here and elaborated again in Unit 16. The unit contains a number of suggestions about the directions of positive change. What would you do tomorrow?

Appendix 1

A pre-school community project in Scotland; a brief case study

by Jean Barr

Introduction

The pre-school community project described here forms part of a larger project which was set up in three areas for priority treatment in Glasgow—areas which were depicted in the agency's urban aid submission as places 'where problem families and children are many . . . where parental responsibility for children can be minimal, where a dependent attitude of the adults on the help and support of the state is the norm and where responsibility for their community is accepted by only one or two outstanding individuals'. The main objective of the project (in line with Strathclyde Region's community development strategy in areas of need) was to involve the parents in these areas in their children's learning by, for example, helping them set up and run their own pre-school services. A central belief of the initiators of the project was that through encouraging local leadership and self-help, communities could be 'regenerated', a belief underpinned by the view, expressed in an early report, that:

> if ways can be found to involve parents in the play and learning of their babies and under-fives and if this stage of family life can become enjoyable and full of interests and events, then many of the problems that lie ahead for older children and family relationships will lessen or even disappear.

The project, then, is one attempt to put into practice what is now an orthodox view in pre-school thinking, particularly in relation to disadvantaged children: '. . . it is only by taking as its focus neither the child nor the parent, but the parent–child system that early intervention . . . achieves its staying power' (Bronfenbrenner, 1974).

Before examining the project itself—and in particular how the assumptions lying in the background affect the practical realities of the project—it is worth looking briefly at the area and the community.

The community

The area

A peripheral, inter-war, council housing scheme, the area in which the project is housed comes top of Europe's league table for multiple deprivation. The statistics, which indicate high unemployment, a high incidence of 'problem families', single-parent families and so on, say nothing about the flora and fauna of the area: 'there were more rats than people running through the closes'. Mrs C describes the effects on herself of living in overcrowded, damp conditions: 'I was down to 6 stone 10 pounds. There were beetles running around and the housing just said they were harmless. There were beetles and cockroaches and wee white things that moved like lightning in the bedroom.'

One man went to the housing department, interested in finding out more about a particular mould growing on his walls:

> 'What would you say this is?' he asked.
> 'Orange peel?' offered the official examining it.
> 'In that case,' replied the tenant, 'you'd better put up my rates. I've a fucking orchard in my hoose.'

Dampness has become a problem since the area underwent environmental improvement. In the wake of this a social work project was set up—to bring about 'social improvement' through community development. From the start, the pre-school project had close links with the urban-aided social work project.

Women, work and the family

Women in the area, like men, work or would like to work for intertwined reasons, but the most pressing is economic necessity. Poverty or the threat of poverty dominates most people's lives here. The work available to women is low paid, menial, and often done at inconvenient hours.

Everything that could be called a child-care resource is filled to capacity and beyond. Most women have a working knowledge of who qualifies for which form of provision: 'If you're not a single parent and you're not battering your child, you've no chance of a place in the day nursery'. Even such 'priority' cases are not catered for, which can mean a depressed single parent who wants to work—'I'm sleeping my life away'—looking after her own two year old (who stutters in other adult company) as well as her neighbour's two children so that her neighbour can work. She, like many other single parents in the area, is housed in a ground-floor flat in the most dilapidated part of the scheme. Nobody wants to live there.

Mr and Mrs B both work full-time. Together, they bring home £80. He works at night and looks after their two year old and three year old during the day. He sleeps most of the time.

A community worker says, 'Women run life almost totally here.' They provide the ties binding extended families which, more often than not, means grannies and aunties looking after children so that their other female relatives can go out to work, such as Mrs McD who looks after her alcoholic daughter and the daughter's three boys. When her other daughter took a job she also took care of that daughter's two year old. All this, along with a job as a night cleaner. The second daughter finally had to give up her work 'because my mammie wisnae well'.

The nuclear family is not always kind to women or children in the area:

> *Jean H* Until I had C [her youngest child] I always had black eyes. He'd bang me off the four walls. Until one night C got up and jumped on top of him when he had me on the floor. He got an awfie shock. He never did it in front of the children, you see.

She, like other women in the area, invests heavily in motherhood:

> I've been told I look stupid without a pram. I go down the road now and I don't know what to do with my hands. I had a phantom pregnancy before I had the last one. I went the full nine months and the day I was due I went flat.

Some women are not allowed out by their husbands, even to a women's night: ' "Who'd you rather go out with—them or me?" Often as not it's them but I cannae say that.' Some women walk out but come back because of the children. Others try a different tactic: 'I had his bags packed and he sits for *two hours* getting his shoes on. "My name's on the door," he says. So I says, "Well, take it with you and I'll get one wi' *my* name on it!".'

There is extensive use of tranquillizers, treating symptoms ranging from temporary boredom: 'If I get fed up I just get on my coat and go up the road to my mammie,' to a state of almost clinical depression:

> I cannae see any future. I can't see how to survive here. I keep tae mysel'. The ceiling's falling doon, see? The kitchen's been flooded four times. I cannae take any mair. I'm in a big fortress with a big wall up, can ye understand? I'd be lost without E.

Her three year old, E, has only one playmate: 'a lassie of 14 upstairs who isnae right'. She keeps her in 'because of the stolen motors . . . they drive them around in the street and set fire tae them.'

The back greens are dangerous too, with broken glass and, since the 'facelift', badly designed play equipment.

Mutual suspicion between families is fanned in some cases by fear of being 'shopped' for working whilst on social security or, in the case of single parents, for having a man in.

Characterizing people in the area as having dependent attitudes and as lacking in responsibility for their children and community hardly squares with the lives and experiences of women in the area. Take three women, each of whom became progressively more involved in the project by different, but, in the end, similar routes. Liz speaks of her children: 'Maist of the time it's them that counts. Maybe I'm just getting older. I've just resolved the only important thing in my life is my weans. It's all I'm interested in.' She describes the birth of her first child and the state of her marriage:

Then Jenny was born and she was beautiful . . . her lashes long and silky. They had tae cut me. It was a breech. I was stitched frae here tae here. I just said, 'God, Liz, ye cannae even dae that right.' When my husband came in he looked at her and said 'That's no mine.' He'd beat me up . . . no just a bash . . it wis feet, fists intae the stomach, face. I wis in the kitchen . . . he got me up against the wall, jumped on me and kicked me. Then I heard him clear his throat. Ye can take so much. And that wis it. I wis nothing, just his tae dae what he wanted with . . . When he finally left I just sat and cried and cried . . . just the relief. Jenny came up and said 'Mummy I love you,' and I said, 'I love you tae, hen. We'll make it all right.'

Of work and dependence:

I'd have worked if I could . . . I went tae the security and they told me I couldnae work because the children were too young. I'd love tae get out and be independent and get off the social . . . I'd an investigator in. I said if I'd a man wid I sit in this hovel? He looked aboot the hoose and asked how I got that and that. It's very degrading . . . But a job wid need tae be a full-time one tae be worth it because the social said I could only earn £6 so I couldnae get a job. Naebody wants ye at 40. So I've tae sit on the social. I've thought of trying two jobs but it'd take everything oot of ye and ye'd have nae time for the weans.

Helen, one of the area's 'weel kent faces', developed the cafe facilities in the neighbourhood centre at part of the project: 'I find the greatest thing in the world for most women is tae get a cup of tea made for ye . . . most mothers get their kids out tae school with nothing in their own stomachs.'

In addition to developing the cafe, Helen was one of the most energetic and successful fund-raisers. She also had a job as a cleaner in the centre complex. So she worked from 6 am until late afternoon and was paid £21 in total for her cleaning work. It is, she says, 'compulsory' now for women to work.

Regarded by leaders of the project as an inadequate, neglectful mother, who treats her husband badly, she speaks of her teenage daughter who refuses school: 'She's really screwed up. Three years ago she got attacked by six boys who're at the school. They stripped her . . . and . . . stood on her feet . . .'

Of her husband:

He takes nae responsibility. He wis wrapped in cotton wool. I wis brought up strict. He'd just put money for the messages on the mantlepiece. Bills I'd never see. I thought he wis paying them. Then a man comes and says, 'Right, you've got 28 days to pay.' By this time I'm cracked up completely. My mother died in February. I'd a miscarriage of twins and debts of £300–£400 I'd nae idea aboot. And then he marched out. I didn't know what'd hit me . . . It wis just an existence day in day oot and the kids notice. I decided I'd go out and work. I paid back the furniture money out of any wee job I could get. We're by that patch now. Now I've got some independence and it's taken years. It's made a difference. Now we sit and talk. But I'd every right tae treat him with the contempt he treated me with.

Pat started her involvement in the project a few months after her mother died. She used to spend every day looking after her mother in her house, then back to her own house to look after her family. When her mother died:

I just used to sit in the house. But I'm no' in much now. My husband disnae mind me coming here [the project], but if I said I wis at Betty's, say, I couldnae do that. There's no way I could get out on my own. Bingo's all right because it's a big crowd.

She speaks of work, paid and unpaid, and her husband's attitude to it:

I didnae feed him for three months and didnae take money from him except to feed the kids. Once he asked for stew—and paid for it . . .

He widnae let me work when the weans were younger. I really wanted to, just to get out . . . even to clean up someone else's dirt. I wis a jack-of-all-trades after school. I wis in a whisky factory for six years, packing, filling and wiring the cases. It wis a man's job. There wis naebody staundin' over the top of ye. I'd like a job noo tae fit in with school but ye cannae get them. One wage isn't enough. I want tae gie them what I didn't get.

The project

The main part of the project, the family centre, is housed in a neighbourhood centre which is sandwiched between a nursery school and a primary school. For the early years of its life the pre-school project shared this location with a community education project—which was responsible for managing the centre—and a community industry scheme (the biggest employers of local labour moved away in the sixties). Conceived as forming the heart of a network of community-organized pre-school groups, the centre was to be the focus for a number of facilities and activities, initiated by project leaders from outside the area whose concern, however, was to encourage local women to take on, gradually, more and more responsibility. There was a playgroup which met in the centre before the project moved in. This, together with the nursery school, provided a pool of mothers for the neighbourhood centre.

With books borrowed from the local library, a small community library for children up to seven was started. A toy library and play-market followed. These were open one day a week but suffered from 'undermanning' and under-use. Fund-raising was a continuous activity. One large room in the centre was developed into a meeting place/cafe.

A 'preparation for parenthood' course for non-certificate pupils (all girls) from the local secondary school took place in the centre. When one of the original tutors became project leader this provided part-time, paid work for two of the local women involved in the project.

Play workshops were put on for mothers who thus learned how to make dough and other things. Informal 'learning through doing' and 'by example' were the methods favoured against a more formal approach to parent education.

A home-play visiting scheme ran for 13 weeks, with three local volunteers (already in 'leadership' roles in the project) paying weekly visits to families referred to the scheme by social work and health departments. A small family centre was opened in a flat in the most socially deprived part of the area several months after the end of the home-play visiting scheme.

One key element in the project's organizational structure was established fairly early on—the mothers' committee. Its formation was regarded by project leaders as a big step forward. In a revised form, this group was intended to form the community element of the new management structure for the neighbourhood centre which would become necessary when the community education project moved to a new community centre.

The growth towards community self-help and parental involvement

Evaluation of this project (which was carried out over a period of 18 months) was conducted and written up in the belief that developments in pre-school provision have always been intermeshed with dominant ideologies, e.g. 'motherhood', 'parenthood', 'the family', and 'welfare', as well as with political and economic factors. The needs of children and what provision to make for them are never established on the basis of 'neutral' theories.

Embedded in and underpinning the day-to-day practice of the project, lying behind its stated aims and objectives, are various assumptions—stated and unstated theories and values—which the case study sought to draw out. Stated baldly, these are:

1 Parents should have a bigger say in the education of their children as of right. However, since attitudes of dependence have been bred into people in areas like this through their relation to the welfare state, stepping stones must be carefully built towards taking on greater responsibility and towards exercising this right: 'Here, it isn't all given to them. They have to do things for themselves. It builds confidence, self-reliance. It's a growth thing' (project leader).

2 Many mothers (sic) *cannot* meet their children's needs because their own developmental needs were not met by *their* mothers when they were young. So as not to repeat this 'cycle' (of deprivation), they have to learn different standards of childcare and experience the play they were denied: 'Until they have the opportunity to catch up on the stages of development which they missed as children, they cannot meet their own children's needs' (project leader).

3 The needs of women and their children are compatible. There is the possibility of

mutual growth, for: 'if mothers take part in the provision of play for their children . . . their own growth as individuals takes on a new impetus' (project leader).

Thus, for the benefit of children and women themselves (*and* the community—see (4) below), mothers have to be discouraged from 'handing over' their children to professional child carers. This will just represent another failure for them.

4 This approach will help stem family breakdown and contribute to the regeneration of the community.

There is, then, some talk about 'rights' but this is subordinate to the dominant frame of reference which concerns 'needs' and 'stages'. There is a definite tension between the democratic principle expressed in (1) and the emphasis on changing what are seen as culturally-induced attitudes and beliefs. Indeed, this was a source of a number of strains in the practical working of the project. Right from the start—'How do you put into their hands what's theirs when they don't want it?' (project initiator)—the paradox involved in moving into an area to meet needs not voiced by the people themselves, needs which did not necessarily match the felt needs and wants of the people, did not go unnoticed.

The way forward—'slowly, slowly, one step at a time'

Project leaders had to 'facilitate' the process of 'growth' on the part of individuals and groups. Thus, in their view, members of the mothers' committee had to mature and learn how to function as a committee in order to understand the complexities of the situation facing them. This could mean that when women raised issues of concern to themselves they were deflected back to the objectives of the project leaders. In this way opportunities for discussion in the women's own terms were missed. At one meeting, for example, a disagreement between the chair and another of the mothers over the presence of men at a forthcoming social was interpreted as an example of 'immaturity' and became a reason for mounting a course on being a committee—thus providing a lesson in democracy. At another meeting the possibility of the centre providing day care for the children of single and working parents was raised by a single parent member of the committee. 'It would', she suggested, 'help a lot of people an awful lot'. This too was postponed to get on to the real business of the meeting and did not reappear during the evaluation period. (A majority of women using the centre in fact believed that the greatest child care need in the area was more flexible provision including full day care to cater for the needs of working and single parents.)

Project leaders were in the privileged position, despite their conscious democratic intent, of being able to determine the framework for the development of the project and therefore to define the terms of arguments. 'They still see us as authority—though nice,' spoken with regret by an egalitarian project leader does not indicate a regrettable mistake on the part of the women in the project but an accurate perception of the real relationship involved.

In fact, most women who used the centre were unaware of the objectives of the project. At the same time, tensions between its democratic intent and interventionist nature manifested itself in comments like: 'We're told we're the bosses, then they step in . . . and instead of coming straight oot wi' it, they go roon, aboot an' in and oot.'

Some women, especially those who used the neighbourhood centre as a meeting place while their children were at nursery school, felt that the project had acquired a social work label. They resented this and they stopped coming: 'It's here because this is a deprived area, isn't it?'

The self-help organization of the project provided an arrangement which seemed to reinforce social divisions between women—thus the festering resentment over the playgroup rota: 'Some mothers just dump their kids. It's the same mums who do it all the time. They're just not interested. I could see the point of letting them off with it if they were *deserving* people but they're not.'

Clearly, the degree of openness with which the project was prepared to approach the community was important. Without it, 'enabling' and 'facilitating' move close to 'manipulating'—as the unintended consequence of the mothers not knowing why the project is there in the first place or how it defines their needs and those of the community.

This issue of openness arose particularly acutely over the small family centre which was opened in the most deprived part of the area during the course of the project. Several

months after its opening, a meeting of the management committee for the centre discussed whether the mothers now using the centre were ready to play a part in running it. A paper on the centre had just been written by project leaders. This was aimed at health visitors as it was felt that they were not taking the work of the centre sufficiently seriously. The team leader of the social work project in the area raised the question of whether it was appropriate to distribute a paper on the centre which the mothers had not discussed or seen while at the same time considering involving them in the *running* of the centre.

However, the paper contained remarks about the lack of play between parents and their children in the area, about the 'unobtrusive example of the worker' for the mothers to follow and about the way in which, with encouragement, the mothers' confidence could grow. Project leaders were reluctant to allow the mothers to read this sort of thing although, in the end, it was agreed to show it to them.

It is, of course, extremely unlikely that women in the project would *challenge* this view of themselves and of their community and offer an alternative, even opposing 'definition of the problem' to that contained in the paper. To do so would require shifting the whole ground of the argument (as, in fact, some community workers in the area attempted to do by regarding 'cycle of deprivation' type explanations as misconceived and by seeing the project as reinforcing women's social role; according to this point of view it is their structural position—as working class women—which is the source of many of their and their children's problems).

Opposing arguments *in the same terms*, on the other hand, are relatively easy to mount—like, for example, protesting that parents *do* play with their children (a view which was indeed borne out by the research—although 'play' may have had a different meaning to that of project leaders). Similarly (although going rather further in challenging dominant assumptions and 'meanings' of the project), one woman, back from a conference on 'play', said to me:

> They kept talking about deprivation. Tae me it means weans wi' nae claes, nae shoes and a father who goes tae the boozer every night. There was this woman frae Blackhill who was gettin' really annoyed aboot it. One of the speakers said that deprivation is not being able to choose and that those parents are usually so deprived that they can't play with their children . . . they don't know how tae. I think it's no' that they can't. It's that they don't *want tae* . . . and all the time wee Ethel wis duntin' me as I wis tryin' tae write.

Not surprisingly, women who were involved in the project, either peripherally or heavily, were involved for reasons quite unconnected with the *project's* dominant purpose. Liz, for example, commented: 'Most of the voluntaries are here because for one reason or another they *cannae* work'. Of the most regular attenders, some live in poor housing conditions from which escape is in itself a relief. One young mother who attends the small family centre lives upstairs with nine people in a four-roomed flat. These include her father who is 'done' at 50, her two-year-old son and several brothers and sisters. Some come, in part, to get away from unemployed husbands, others because this is the one place they are *allowed* to come. Some come because they are lonely or, quite simply, because they have nowhere else to go: 'If I didn't come here I'd know nobody.' 'If I didn't come here I'd just be sitting staring at four walls.'

Some have no under-fives and may have quite specific reasons for coming. One woman has suffered from both agoraphobia and claustrophobia since her father died and since her youngest child started school: 'I cannae breathe. I imagine the buildings are moving. I'd have a brain transplant, it's so bad.' The small family centre is one place she feels relatively comfortable.

A member of the mother and toddler group meeting at the neighbourhood centre commented to me (rather shamefacedly): 'See that?' (pointing to the project leader getting down on the floor to play with the children) 'That's what we're supposed to do. But I come for the chat.'

The benefits to children from the project are probably an indirect consequence of their mothers having a meeting place rather than a direct consequence of the various 'education for parenthood' activities of the project: 'It's getting out. I've a bit mair patience now.' 'Now I'll sit down with them and just leave the housework. It's mair "Tae hang wi' it, it'll get done." '

Appendix 2

Scottish remedial teachers' responses to their new role

by John Henley

Although a few remedial teachers had anticipated to a greater or lesser degree the 'thrusts' of the 1978 inspectorate report, *The Education of Pupils with Learning Difficulties*, the majority were stirred, even inspired, by the report and its implications. In the four years since, many have become disciples, others reluctant adherents or lapsed devotees, but few have remained obdurate heretics. Few have been unaffected and for most the change of role and expectation has proved both disturbing and emancipating.

Undoubtedly, many remedial teachers have revelled in their enhanced roles. Readability levels have been computed, worksheets revised, advice presented and a wide variety of team and co-operative teaching schemes begun. Freed from their converted broom cupboards, remedial teachers have liaised, consulted, cajoled—some few even arrogating to themselves powers of censorship over material and method so that 'one feels at times that there is a need for a new document to state what the HMI report didn't say!'

Other remedial teachers, having made unwise blanket offers of assistance, have been inundated by requests for help, so much so that any assistance proferred was either superficial or so belated as to be unappreciated. In some schools remedial staff were pitchforked willy-nilly into the new roles by the head teacher despite all their protesting cries and the results have been no advertisement for the report; elsewhere remedial staff have flung themselves into the crusading, proselytizing role without waiting for the concomitant organizational changes and support of senior staff and results have been equally disappointing. Yet not all of the experiments of these transitional years have been hasty or ill-conceived or without positive lessons, and many insights can be gleaned for the further implementation of the seminal report and for future training programmes.

For some remedial teachers the scope of the new roles has been less demanding than the strains put upon personality. The move from the periphery to the centre of the educational stage has meant an unwelcome limelight for some timid souls. Other more forthright characters, long accustomed to conducting their classrooms in their own fashion, have found it hard to consult, to compromise or to concur. All have had to learn positive diplomacy through trial and error. Some 'specialists in learning difficulties' have come to see the responsibilities of a position from whence it is too easy to parade hobby-horses as unassailable examples of good educational practice.

> I was conscious that my passionate belief in the mixed-ability ideal was colouring the advice I gave, taking no heed of the actual organization within which I worked. So easy to shrug off the experience of the mere subject teacher who wasn't a specialist in learning difficulties. Somehow, I resolved, I must stand back a little to review what I was saying. After all there is always more than one way to skin a cat!

Other remedial teachers have found it difficult to reconcile the new 'unique' role with the more traditional teaching roles. 'Talking isn't working' has been used to dismiss the time-consuming consultative role. If teacher productivity is measured by the number of bodies in a class or by the dozen of books marked, then only by the production of 'appropriate materials' by the yard can remedial teachers escape the scepticism of their hard-pressed colleagues. For some the attempt to maintain credibility in the eyes of colleagues through traditional methods has meant a lesser credibility and effectiveness for the new roles.

Co-operative teaching has been perhaps the easiest and first practical implementation of the new roles. It too has not been without its problems: 'At first I felt a bit like a piano player without a piano, being a teacher without a room.' Two teachers within the one classroom may easily have differing concepts of discipline, differing expectations of the children, even differing lesson aims. Some remedial teachers respond by 'getting in at all costs', others soon depart seeking more compatible climes. It is not always easy to adopt the philosophical stance that, 'just as we allow for individual differences among our pupils, so should we allow for individual differences among colleagues.' Remedial

teachers worry over their image—are they just auxiliaries, 'the helpers', or 'not the proper teachers'? Others are concerned over the cost-effectiveness of two teachers to a class, expecting results far in excess of reality. For many the logistics of adequate pre-lesson planning and post-lesson review are insuperable barriers to maximum efficiency: yet for others this unpreparedness is seen as giving them a valuable 'pupil's eye view' of the lesson and they seem blessedly content with their 'pedagogy on the move'!

There are further reservations.

> I am worried that the presence of remedial teachers might become the substitute for the development of appropriate methods, and the remedial teacher may be merely helping the pupils to try and cope with the unsuitable mixture as before.

Yet despite these difficulties of co-operative teaching, only recently coming under the review of research and evaluation, its positive features must not be overlooked. Apart from the obvious benefits of well-prepared co-operative teaching effectively carried through, it can become, as the inspectorate's report suggested, the first step towards the consultancy role. It also can afford valuable insights: 'I can more easily see the class teacher's point of view and appreciate the difficulties his particular subject presents him with—and that cannot be a bad thing.' Many teachers would agree with the reluctant co-operative teacher, deprived of her remedial class against her will, who eventually admitted, 'It really does work—much better than I expected,' or support the view of the remedial teacher working with a maths colleague: 'Two years ago when we started I admit I was worried but now I would say with my hand on my heart that the children are doing much better than I expected. I wouldn't think of changing back to the old system now.'

The inspectorate report made remedial teachers think not only about their own roles and effectiveness but also about the system within which they work. Over and over again in their thinking they stress that no individual response to the report will be effective in isolation. To succeed, the new roles must be set within a supportive organizational structure, even if it be one that merely recognizes, and provides, the essential element of time. Thus co-operative teaching is best when preceded by consultation and this is hardly efficient when snatched from intervals or lunch breaks. A concerned organization will allow timetabled periods for consultation, for attendance at departmental meetings and for the myriad other facets of the remedial roles. Ideally a concerned management, keen to make best use of the remedial specialist's expertise, will consider new organizational forms, such as block timetabling, to afford a wider scope. More vital, however, than even facilitating organizational changes, than even the provision of adequate staffing and resources, must be the school's overall recognition of the needs of children with learning difficulties. 'It is the school's approach to the slow learner that is essential. From head down everyone must be aware of the problem.' There must be, as the inspectorate urges, 'a whole school policy.' All staff, all departments, must be aware of the part they can play in the more efficient learning of children with difficulties. To this end, a senior member of staff with responsibility for curriculum development would appear a *sine qua non*, not only to support the efforts of remedial and other staff but also to represent the 'whole school policy' at senior staff level. Given a strong 'whole school policy' for children with learning difficulties, many of the problems, self-doubts and reservations of remedial teachers would be greatly eased.

Appendix 3

Moray House Diploma in Learning Difficulties: summary of course content

This is a sessional full-time course, divided between college-based studies and school placements and visits.

College-based studies are divided into the following course units:

1	Curriculum development—models, design, evaluation, etc.	37½ hours
2	Pedagogy—diagnostic teaching and other teaching approaches	37½ hours
3	Factors affecting pupil performance—psychological, sociological, curricular, organizational	60 hours
4	Assessment—purposes, techniques, management	30 hours
5	Biographies—case studies using a variety of media	10 hours
6	Consultancy—understanding the system and making it work	47½ hours
7	Language in education—understanding and implementing a school language policy	7½ hours
8	Wider perspectives—school and community	15 hours
9	Literature review—seminar discussions on reviews of relevant literature	20 hours
10	Understanding and helping troubled children—emotional disturbance and behaviour problems associated with adolescence	5 hours

School placements will be in two blocks of five weeks, one at the beginning of Term 2 and the other at the beginning of Term 3.

Visits will take place, one day per week, during the college-based period.

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Figures

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The course

This text forms part of an Open University course, E241 *Special Needs in Education*. The complete list of units in the course appears below.

Unit 1/2 Special biographies	Unit 10 National perspectives
Unit 3 Family views	Unit 11 Biology and handicap
Unit 4 Education for adult life?	Unit 12 Psychology and special education
Unit 5/6 A special curriculum?	Unit 13 Handicap is social
Unit 7 The professionals	Unit 14 Eradicating handicap
Unit 8 The powers that be	Unit 15 Research in special education
Unit 9 Origins	Unit 16 An alternative system: a special imagination

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Tony Booth is a lecturer in special education at the Open University. He graduated with a degree in psychology and philosophy before working in programmed learning, teaching in a comprehensive school, and qualifying as an educational psychologist. He has worked for three local education authorities as well as in departments of child psychiatry. He has also been involved in research on children's learning at Guy's Hospital and, at Cambridge University, on physically disabled adults and the integration of mentally handicapped children.

For this course, as well as this unit, he has written Units 1/2, 10 and 13 and is one of the authors of Unit 16. He is also co-author, with June Statham, of the case studies which are set reading—*The Nature of Special Education* (1982, Croom Helm/The Open University Press). He has also written *Growing Up in Society* (1975, Methuen).

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